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CONFIDENTIAL PATIENT DATA FORM

CONTACT INFORMATION

Date: _____ Date of Birth: _____ Age: _____

Name: _____

Address: _____ (Street/City/Zip)

OK to send mail to this address? ___ No ___ Yes

Cell Phone: _____ [ok to call? ___] [ok to leave msg? ___]

Home Phone: _____ [ok to call? ___] [ok to leave msg? ___]

Work Phone: _____ [ok to call? ___] [ok to leave msg? ___]

E-Mail Address: _____ [ok to e-mail? ___]

Social Security Number: _____

Name & Number to phone in case of emergency: _____

Employer: _____ How long? _____

Relationship Status: ___ Single ___ Married/Partner ___ Divorced ___ Widowed

Spouse's Name: _____ Employer: _____

Children: Yes ___ How many? ___ No ___ If Yes, provide names and ages:

REFERRAL INFORMATION

Current Reason(s) for Seeking help at this time? _____

How would you rate the severity of your problem?: Mild ___ Moderate ___ Severe ___ Very Severe ___

Who Can I Thank for Referring You to Me? _____

INSURANCE/BILLING

Will you be requesting a monthly statement? Yes No

Who Will Pay for this Account? _____

Health Insurance? Yes No Name of Carrier?: _____

Payor's Employer? _____

HEALTH INFORMATION

Family Physician: _____ Phone: _____

Address: _____ Date of Last Appt.: _____

Please list any current medications you have used during the last year (specify frequency & amounts):

Any medical problems, surgeries, or accidents in your history?:

Please list previous mental health treatment (dates/therapist/helpful experience?):

Anything else you would like me to know about you? _____
