PATIENT INFORMATION SHEET

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Welcome. Please complete as much or as little of this form as you like.

Name: _____ DB: _____ Age: _____

Local Address:

_____

Birthplace: _____ Hometown:

_____

Preferred Phone: _____ Cell Home Work OK to leave msg? Y N

Secondary Phone: _____ Cell Home Work OK to leave msg? Y N

Email address (only used with your permission):

_____

Social Security Number: _____ Cultural/Ethnic background:

_____

Emergency Contact (name, phone, relation):

_____ Health Insurance Carrier: _

_____ Member ID#:_____

Who referred you?: _____

FAMILY: Please list all family members and any significant others. Please include: Name, Relationship to you, Age, Location, Occupation, and any Mental Illness.

_____

_____

_____

EDUCATION AND EMPLOYMENT: Please list current and recent significant **employment** (position, company, location, and time frame), and **education** (school, degree, location, and time frame).

_____

HEALTH: Please list Significant Medical History (chronic conditions, accidents, major illnesses, surgeries):

_____

_____

_____

Current psychiatrist: _____ Current psychiatric medication:

_____

Past psychiatric medication:

_____

Other current medication:

_____

PREVIOUS PSYCHOLOGICAL TREATMENT (please list all past psychological treatment, including any hospitalizations; including reasons, location, and time frame):

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CURRENT MENTAL HEALTH: Please check all of the following items which are concerns at this time, and circle those which are most important.

Abortion issues	Divorce, separation	Legal problems	Self-injury, mutilation
Abuse – emotional, physical	Drug use	Loneliness, no friends	Self-neglect, poor self-care
verbal, sexual, neglect	Eating problems	Memory problems	Sexual assault
Academic issues	Emptiness	Mood swings	Sexual concerns
Advisor/faculty concern	Family relationships	Motivation	Sexual harassment
Aggression/violent behavior	Fearing failure	Overly responsible to others	Sexual orientation/ identity
Alcohol use	Fears, phobias	Overly sensitive to rejection	Sexually transmitted disease
Anger, arguing	Financial problems	Panic attack	Shame
Anxiety, nervousness	Gambling	Perfectionism	Shyness, oversensitive
Body image	Guilt	Peer relationship concerns	Smoking, tobacco use
Career concerns, choices	Harassment	Pregnancy	Sleep problems
Childhood issues (yours)	Health, medical concerns	Prejudice/bias concerns	Stress
Children/parenting concerns	Hallucinations	Procrastination/time mngt.	Suicidal thoughts
Compulsive behaviors	Identity issues	Racial/ethnic concerns	Tiredness, fatigue
Computer excessiveness	Impulsive, out of control	Repeated troubling thoughts	Violent thoughts
Concentration	Independence from parents	Relationship concerns	Withdrawal, isolating
Decision making, indecision	International student concern	Relationship violence	Worthless feeling
Grief issues	Irresponsibility	Religious/spiritual concerns	Other
Depression, sadness, crying	Learning disability	Romantic relationship	

Signature _____ Date

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