NORTHLAND CLINIC

PATIENT INFORMATION SHEET

Date of Appointment_____ Social Security #_____ Driver's License#_____

Client Name_____Age_____Sex_____Date of Birth_____

Address_____City_____Zip_____

Home Phone_____Work Phone _____

Cell Phone_____E-mail Address: _____

Marital Status: Married Single Divorced/Separated Widowed

Spouse's Name_____Birth Date _____

In Case of Emergency: Name_____Relationship_____Phone _____

Employment: Are you currently employed? Yes No Part-Time Full-Time

Occupation_____Employer _____

Employer Address_____City_____Zip_____

Education (indicate highest level achieved)_____

Children or Others in Home

Name _____Age_____ Name_____Age_____

Name _____Age_____ Name_____Age_____

Who referred you or how did you become aware of our services? _____

Medical Insurance Information:

Insurance Company Name_____Policy # _____

Effective Date of Policy_____Group# _____

Subscriber Name_____Social Security # _____

PLEASE COMPLETE IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT

Responsible Party

Last Name_____First Name_____Middle Initial _____

Address: _____

Relationship_____

Should psychiatric hospitalization become necessary, indicate a hospital preference _____

_____ or circle NONE

Should you become unable to make decisions about your mental health care, who should we contact to make these decisions on your behalf? _____

I understand that any charges not covered by my insurance will be my responsibility.

_____ _____

Insured or Guardian Signature Patient Signature

Please Turn Over Page

Physical Status

Present state of general physical health Good Fair Poor

Please describe any physical disabilities _____

_____

Approximate date of last complete physical exam: _____ Results _____

_____

Name of Primary Care Physician _____

PCP's Address _____ City _____ Zip Code _____

Please list any significant past and present medical problems _____

_____

_____

Please list any medications you have taken for emotional/psychological/behavioral concerns and how effective they were

Medications	**When Taken (Approx.)**	**Response/Reaction to Medication**

Please list all current medications (including both prescriptions and over-the-counter)

Medication	**When you Began this Medication**	**Response/Reaction to Medication**

Please list allergies _____

Have you ever been hospitalized for psychiatric issues? If so, when, where, and for how long? _____

_____

_____

Have you been involved in counseling or therapy for emotional concerns in the past? If so, where, when, and for how long?

_____

_____

If applicable, please indicate the amount and frequency of the following:

	Present Use	**Past Use (if different)**
Alcohol		
Nicotine		
Caffeine		
Other Substances		