MC Wellness
LIVE WELL. DO BETTER.

Patient Information

Patient's Name_____Date_____

Address_____ Apt _____

City _____ State _____ Zip Code_____

E-mail _____OK to contact? ☐YES ☐NO

Home Phone _____ OK to contact? ☐ YES ☐ NO

Cell Phone _____ OK to contact? ☐ YES ☐ NO

Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Employer _____Occupation _____

Number of different jobs in past 3 years: _____ Last Grade / School Completed_____

Social Security #: _____-_____-_____

Marital Status: ☐Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married, separated, divorced, or widowed, how long: _____

Name of Spouse/Partner_____ Date of Birth ___/____/_____

Have Children: ☐ Yes ☐ No If yes, how many children? _____

Name of Children/Others in Household	Relationship	Date of Birth	Age	Lives with You?
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No
_____	_____	_____	_____	Yes / No

Physician Name _____ Date of last physical: ____/____/_____

Are you taking medication(s): ☐ Yes ☐ No If yes, Name, dosages and for how long? _____

_____

Any health issues: _____

In Case of Emergency:

I authorize to contact _____ Relationship_____

Phone Number _____ Alternate Phone Number: _____

How did you hear about us?
☐ Friend/Family ☐ Our Website ☐ Psychology Today ☐ Other_____

Person Completing Form: _____ Relationship to Patient: _____