

1. Contact Information

Date: _____

Last Name(s): _____ First Name(s): _____

Date(s) of Birth: _____ Age(s): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone(s): _____

E-Mail Addresses: _____

How and when do each of you prefer to be contacted: _____

Have either of you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? Yes No

If yes, please explain: _____

Have either of you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please explain: _____

Reason for today's appointment: _____

How did you hear of this practice: Web Referral Other: _____

2. Employment Information

Position(s) and length of employment: _____

3. Educational Information

Please indicate highest level of education completed for both of you.

- GED High School Trade School College Graduate

Highest Degree(s): _____

Certifications: _____

4. Medical Information

Primary Care Physician: _____ Phone: _____

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, convulsions, seizures and/or any other medical conditions that either you have had:

Do you have any allergies? Yes No

If yes, please them: _____

Please list all prescribed and over the counter medications, drugs or other substances (vitamins, herbs) that either of you take or have taken in the last year.

Drug	Dose	Reason	Taking Presently

What type of physical exercise do you get daily? _____

Please fill in the following information for your children or stepchildren.

Name	Age	Relationship Status	Relationship Issues

Please briefly describe your families of origins:

Please describe you relationship with your in-laws:

Thank you for your time in completing this form.
This is a strictly confidential patient medical record.