CONFIDENTIAL PATIENT INFORMATION SHEET

Today's Date:____________

Name:____Date of Birth:_____________

Street Address:____

City:_____________________________________State:__________Zip Code:_______

Telephone numbers: Home____________Work______________Mobile_____________

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)
(*circle one*)

Employer:___________________________________Occupation:__________________

Address:____

Referred to this office by:____

Contact in case of
Emergency:___________________________________Phone:_____________________

Relationship:_________________________________

Family of Origin: Mother: ____Living ____Deceased Current age/age at time of death______

Father: ____Living ____Deceased Current age/age at time of death_______

Siblings (age and gender): ____

Confidential Patient Information

Name: ____

Reason for seeking therapy: ____

____

Please circle the symptoms you are currently experiencing.

Symptom	Mild	Moderate	Severe	For how long?
Depressed Mood	1	2	3	
Hopelessness	1	2	3	
Suicidal Thoughts	1	2	3	
Appetite Changes	1	2	3	
Weight changes	1	2	3	
Sleep Problems	1	2	3	
Poor Concentration	1	2	3	
Obsessive thoughts	1	2	3	
Daily Rituals	1	2	3	
Strange, Unusual thoughts	1	2	3	
Tension/ Anxiety	1	2	3	
Panic Attacks	1	2	3	
Memory Problems	1	2	3	
Compulsive Behavior	1	2	3	
Hostility or Anger	1	2	3	
Violent Acts	1	2	3	
Social Isolation, Loneliness	1	2	3	
Sexual Problems	1	2	3	
Relationship Problems	1	2	3	

Please Circle:

Alcohol Use: Never 1-4 times per month 3-4 times per week Daily

Amount: 1-2 drinks per sitting 2-4 drinks per sitting 5 drinks or more

Intoxication: Never 1-4 times per month 3-4 times per week daily

Circle any used: None marijuana opiates sedatives stimulants
cocaine hallucinogens nicotine caffeine

How often: ____

Have you been in therapy before? If yes, when and with whom?________________________

____

Have you ever been hospitalized for a psychiatric illness? If yes, please explain:__________

____

Are you currently under the care of a psychiatrist? If yes, please provide his/her name:

____

Any medical problems (including allergies)? ____

____

List all medications (including non-prescription) that you are currently taking:___________

____

Does anyone in your family have a mental illness?____________________________________

____

Has anyone in your family ever attempted suicide?____________________________________

____

Have you ever been arrested?____