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PATIENT INFORMATION
This information is to help me get to know you better. Please answer to the best of your ability and level of comfort.

Date: __________

Name (Last)___________________________ First:____________________________________

Street Address: ____

City:__________________State:__________Zip:__________

Phone Numbers: (H)_______________(W)_________________(cell)_____________________

DOB: ________________

Please circle: Single • In Relationship • Domestic Partner • Married • Separated • Widowed

Emergency Contact:____

Name Phone Relationship to you ____

Cultural identity/Ethnic Heritage: ____

Who did you feel safe with as a child?____

Who do you go to for emotional or practical support now? ______________________________

Reason for seeking therapy at this time: ____

Prior Therapy? When? How long? Primary Issues?_____________________________________

Substance use: current/past? ____

Medication: Dosage, Prescribing Physician? When?____________________________________

Medical/Health related issues?____

Other information you would like me to know when we meet: ____________________________

How did you hear about me? ____

Thank you!