Information Form

Patient's Full Name: _____

Patient's Date of Birth: _____ Age: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

How do you prefer communication, such as to schedule or reschedule appointments (please circle)? Home phone Cell phone E-mail_____

May I leave a message on the answering machine (please circle)? YES NO

Emergency contact person: _____

Relationship to you:_____ Phone: _____

Physician Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

Family Information: Please list any children, including full/half/step/adopted

Name Relationship Age History of illness

_____

_____

_____

_____

Other people living in the home: _____

Primary language spoken in the home: _____

Name of significant other and relationship: _____

Do your children reside in the home with you (please circle): YES NO

What are your current custody arrangements: _____

_____

Are you currently involved in any family court matters (please circle): YES NO

If yes, please describe: _____

Medical History

Date of most recent physical exam: _____

Have you ever had a concussion or serious head trauma (please circle): YES NO

Have you ever had a seizure (please circle): YES NO

Do you have any allergies (please circle): YES NO

Please list any medications you are currently is prescribed, including name and dosage.

_____

_____

_____

Please list any significant medical conditions you have been diagnosed with, including follow-up care instructions. _____

_____

Educational History

Highest grade completed: _____ School name: _____

Were you ever retained (please circle): YES NO

Did you have an IEP (please circle): YES NO

Please list any special school accommodations: _____

_____

Family Mental Health History

Is there a history of mental illness in your family (please circle): YES NO

If so, please describe _____

_____

Is there a history of learning disabilities in your family (please circle): YES NO

If so, please describe _____

_____

Is there a history of substance abuse in your family (please circle): YES NO

If so, please describe _____

_____

Mental Health History

Have you ever previously attended counseling or therapy (please circle): YES NO

If so, please describe _____

_____

Have you ever been hospitalized for a psychological reason (please circle): YES NO

If so, please describe _____

_____

In your own words, please describe the reason for today's appointment, including any current concerns _____

_____

_____

Legal History

Have you ever been arrested or charged with a crime (please circle): YES NO

If so, please describe _____

_____

Have you ever been sentenced to a state or federal facility (please circle): YES NO

If so, please describe _____

_____

Do you have any pending legal charges (please circle): YES NO

If so, please describe _____

_____