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CONTACT INFORMATION & PERTINENT HEALTH HISTORY

Please provide the following information for my records. Information you provide here is held to the same confidentiality standards as anything you tell me during therapy.

Name: ____

Phone(s): Home ____________________ Cell ____________________ Work__________________

Okay to leave a message?: on home phone? Yes / No Cell? Yes / No Work? Yes / No

E-mail address: ____ OK to email you? Yes / No

Which do you *prefer* as default contact? (Circle one): Home phone Cell phone Email

Emergency Contact (Name & relationship to you)

____

Phone(s): Home ____________________ Cell __________________ Work __________________

Your Age: ____ Date of Birth: ____________ Birth Place: ________________________________

Are you: Single ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed ____

Home Address:____

First names & ages of all others living at above address & their relationship to you:

____

____

____

If you are a parent, first names & ages of children *not* living with you & city where they live:

____

____

If you are under 18: Grade in school _____ Name of school: ____________________________

Name of your parent/guardian: ____

Have you previously received psychotherapy or other mental health services? Yes No

If Yes, at what age(s) & for what reason? ____

____

____

Have you ever been hospitalized for a mental health or medical reason? Yes No

If Yes, when & for what reason? ____

____

____

____

Please list any medical diagnoses/problems **or** substance abuse issues (and at what ages):

____

____

____

Do you take or have you taken psychotropic or other prescription medications? Yes No

If Yes, please list by name, dosage if known, for how long, & for what diagnosis:

____

____

____

____

Do you tend to take prescribed medications regularly (according to directions)? Yes / No

Have you ever had inclinations to harm yourself or someone else? Yes No

If Yes, please explain (when, who, and how) ________________________________

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