PATIENT RECORD

Patient:_____ DOB:_____ Current age:_____

Address:_____ City:_____ Zip:_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Gender: M_____ F_____ Self-describe_____ Prefer not to say_____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

Emergency Contact: _____ Telephone: (____) _____

Employer / School Job Title / Grade

_____

Relevant medical conditions (history, current condition, changes in condition)

_____

Medications (dosage, length of time, prescribing clinician)

_____

Allergies / Adverse reactions to treatment

_____

Reason for seeking therapy: _____

_____

Treatment goals: _____

Previous psychological or psychiatric treatment: _____

_____

Psychiatric hospitalizations (dates and locations)

_____

_____

Family history of psychological or psychiatric treatment: _____

Alcohol use: Y / N (# _____drinks weekly) Date last drank_____

Illegal drug use: (past or present) Y / N Date last used: _____ Type:_____

Family history of alcohol or drug use:_____

PATIENT RECORD

Police / Probation involvement (past or present) Y / N Date: _____ Please explain _____

_____

Family Structure (please list others who live in your home / relationship / ages)

_____

_____

_____

Please circle any applicable experiences (past or present)

Anxious mood	Sad mood	Domestic Violence	Traumas
Sexual Abuse	Physical Abuse	Sleep Problems	Eating Disorders
Losses	Learning Problems	Suicide Attempts	Suicidal Ideation
Cutting / Self Harm	Visual Hallucinations	Spending Sprees	Anger Outbursts
Lying	Phobias	Mood Changes	Worry / Fear
Panic Attacks	Poor Concentration	Tearfulness	Fatigue
Hopelessness	Racing Thoughts		

What are your strengths? _____

Challenges? _____

Motivation for treatment: _____

Other significant information: _____

_____

Patient's Signature_____ Date _____

Therapist's Signature_____ Date _____