

**PATIENT INFORMATION FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Employer/School: \_\_\_\_\_

Marital Status: Married ( ), Single ( ), Divorced ( ), Widowed ( )

Emergency Contact/Phone#: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Relevant Medical Conditions** (history, condition, changes in condition):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:** Name Dosage How Often

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Adverse Reactions to Past/Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Previous Treatment:** Name of Provider Purpose Dates

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E-mail Address:** \_\_\_\_\_



Patient Name: \_\_\_\_\_

**Past and Present Use of the Following:**

Cigarettes: \_\_\_\_\_

Alcohol: \_\_\_\_\_

Other Substance Use (i.e. marijuana, cocaine, methamphetamine, etc):

\_\_\_\_\_  
\_\_\_\_\_

Legal Problems as a result of substance use: \_\_\_\_\_

\_\_\_\_\_

**What are your treatment goals?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**<For Staff Use Only:>**

Additional Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DSM IV Diagnosis:**

Axis I: \_\_\_\_\_

\_\_\_\_\_

AxisII: \_\_\_\_\_

AxisIII: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_