**DEMOGRAPHICS/MEDICAL INFORMATION**

Name:

Date:

Who referred you?

**Demographics**

Client Name: D/O/B Age:

Gender: M \_\_\_ F\_\_\_\_ Gender Identity(optional)\_\_\_\_\_ Pronoun (optional)

Sexual Orientation (optional)

Ethnicity:

Address:

Phone (H) (W) (C)

Preferred telephone number to call you at Ok to leave a message?

Emergency Contact (name, phone #, relationship)

Email:

Employer (name, phone #, address) Length of employment?

Occupation:

Name of Spouse/Significant Other:

Address (if different from above):

Phone (H) (W) (C)

Spouse’s/Significant Other’s Employer (name, phone #, address)

Length of employment?

Occupation:

If married (or in committed relationship) how long in current marriage/relationship? :

Previous Marriages/Committed Relationships? If yes, explain:

Children (Names and Ages):

**Educational Information**

What is the highest grade of formal education you completed?

Are you currently enrolled in school?

Medical Information - Current and Past Professional Providers

Reason for coming to therapy now

Family Physician ­­­

Address

Phone Date of last visit

Psychiatrist

Address

Phone Date of last visit

Therapist Address Phone Date of last visit

Neurologist Address Phone Date of last visit

**Previous Psychiatric/Chemical Dependency Treatment** (including provider, type/level of care, DOS and treatment outcomes)

**Medication**

List all current and past psychotropic, overt the counter medications and supplements:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication | Current/past | Date started | Prescribing MD | Dosage | Response | Purpose |
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