CONFIDENTIAL PATIENT DATA FORM

Patient Name:_____

Date of Birth: _____

Home Phone:_____

Cell Phone: _____

Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Referred by _____

*Emergency Contact_____ Phone#_____

Is Patient Married: _____ Length of Marriage: _____

Gender Identity: _____ Sexual Orientation: _____

Gender Orientation: _____ Pronoun Identification:_____

If not Married with Significant Other: _____ Length of Relationship:_____

Number of Children: _____ Ages: _____

Current Medication:_____

Name of Prescribing MD:_____

Last Physical Exam:_____

Name of Physician:_____

Have you had the Covid-10 Vaccination? Date of 1st Vaccine _____ Date of 2nd Vaccine _____

(please provide copy of Covid-19 Vaccination Record Card) or date of appointment:

Are you currently experiencing any symptoms of illness including fever, shortness of breath, coughing, or sneezing?

Have you recently traveled (where and when did you return)?

_____

Have you had any contact with someone ill or who has symptoms of coughing, sneezing, fever, shortness of breath, or in proximity with anyone diagnosed with Covid-19 Virus:

_____

Are there any family members living with you who are currently or recently ill with covid or other major disease? Are you a primary caretaker for an ill family member (other than your own child)?

_____

Are you currently or have you experienced suicidal ideation, intent or action?:

_____

Are you currently or have you experienced homicidal ideation?

_____

Do you have a history of violence, please describe:

_____

Do you currently have or have access to any weapons:

_____

Have you ever been hospitalized for a psychiatric / mental health issue:

_____

Previous Therapist Name:_____ Length of Treatment:_____

Is Family Supportive of Your Being Treatment: _____

Previous Mental Health Treatment

Have you ever participated in RTC, PHP, IOP, TX? _____

When/where:

_____

For how long? _____

Was your previous therapy a positive or negative experience? _____

_____

History of Psychiatric medications: _____

Is there a history of mental illness in your family (please describe)

_____

_____

_____

Trauma History (if you would like we can complete this section together):

_____

_____

_____

_____

_____

_____

Any history of disordered eating / eating disorder:

	Yes	No
Do you use drugs/alcohol	☐	☐
Do you consider them a problem for you?	☐	☐

If yes, what do you use and how often? _____

IF no, are you currently in recovery, how much time: _____

	Yes	No
Have you a history of self-harm	☐	☐

If yes, please describe how often, what method, most recent: _____

_____

Current Living Situation (alone, with others, with family):

_____

_____

What interpersonal resource/ support do you have _____

_____

Hobbies: _____

Highest level of education? Highest grade/degree and type of degree:

_____

_____

Current Occupation? What do you do? How long have you being doing it?

_____

_____

Any past or present legal problems:

_____

_____

What brings you into therapy at this time? Is there something specific such as a particular event? Be as detailed as you can. (attach a separate sheet of paper)

_____

_____

_____

_____

_____

_____

_____

What are your current goals (attach separate sheet of paper as necessary

_____

_____

_____

_____

_____

_____

_____

Please list any medical conditions you are presently experiencing, or have been treated for during the past 5 years:

_____

_____

_____

_____

What else would you like me to know?

_____

_____

_____

_____

Form Completed by (Signature): _____ Date _____

For Minor client, the responsible party is:

Name _____

Address _____

Home Phone#_____ Work Phone#_____

_____

_____

_____

_____

What else would you like me to know?

_____

_____

_____

_____

Form Completed by (Signature): _____ Date _____

For Minor client, the responsible party is:

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Home Phone#_____ Work Phone#_____