

INFORMATION FORM

NAME: _____ DATE: _____

Background Information

Address: _____ City: _____ Zip _____
Telephone: Home _____ Work _____ Cell _____

Can you be called at work if I do not identify myself as a doctor? Yes _____ No _____
Referred by _____

Social Security No: _____ Date of Birth: _____ Age _____

Occupation: _____ Current Employer _____
Title: _____ Highest Grade of Education Completed _____
Degree: _____ Approximate # hours worked per week _____

Married (No. of Years) _____ Engaged _____ Single _____ Divorced _____ Separated _____ Widowed _____
Living with significant other _____ Number of marriages: _____
Spouse or partner's name _____
Spouse/partner's occupation & employer _____

Children Yes ___ No ___

Name:	Sex	Age	Grade/Occupation	Lives with you?

Medical History

Primary Care Physician: _____ Date of last physical exam: _____
List all known allergies: _____

Medical Problems:

List Dates and Reasons For All Hospitalizations and Surgeries:

Lists Medications you Take On A Regular Basis:

Drug name	Frequency/Dose	Reason Prescribed

List Medications you Take On An As Needed Basis: _____

How much alcohol do you drink in a week? _____
How long have you used alcohol _____

How many cigarettes do you smoke each day? _____
How long used? _____

Psychological History

If you have been seen by a mental health professional please list below the professionals you have seen:

Name	Dates	Why?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Dates and Reasons for past psychiatric hospitalizations:

I certify this information is accurate to the best of my knowledge.

Date: _____ Signed _____

Thank you