Date: _____

The questions below are intended to collect information that will help me to work with you. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

I will not contact anyone listed below without your written consent, except when required by law.

Name:_____
(First) (Middle) (Last)

Birth date: _____ Gender: _____

Address: _____
(Number) (Street) (Apt.)

_____
(City) (State) (Zip)

Phone number: _____ May I contact you at this number? _____

May I leave messages at this number? _____

Email: _____ May I contact you via email? _____

In case of emergency, who would you like me to contact? _____

Relationship to you: _____ Phone number: _____

Occupation: _____ Annual income: _____

Place of employment: _____

Employer's address: _____
(Number) (Street) (Apt.)

_____
(City) (State) (Zip)

How did you hear about my practice? _____

Medical

Who is your physician? _____

Contact info for physician: _____

_____

Date last seen: _____ Reason for visit? _____

Do you have any medical conditions or disabilities that I need to be aware of? _____

_____

_____

_____

Current health concerns: _____

_____

Are you currently, or have you recently been experiencing any disturbances or abnormalities of sleep or eating? _____

If so, please describe: _____

_____

_____

Please list all medications that you are currently taking and what they are prescribed for:_____

_____

_____

If you use alcohol, drugs, or any non-prescribed medication, please list them, how often you use them, and how much you use: _____

_____

_____

Psychological

Have you ever worked with a Mental Health Professional? _____

If so, when was the last time you saw a Mental Health Professional? _____

What was your reason for seeing a Mental Health Professional at the time? _____

_____

_____

Have you ever tried to harm yourself? _____

If so, when and how? _____

_____

_____

Have you ever been hospitalized for mental, chemical, or emotional problems? _____

If so, when? _____

Where? _____

_____

Reason for hospitalization and length of stay:_____

_____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

Education

Highest degree earned in school: _____

Area of study: _____

Have you ever been diagnosed with a learning disability? _____

Social

Where were you born? _____

Where did you grow up? _____

If you moved to the Bay Area, when did you do so and what brought you here? _____

_____

_____

What is your current relationship status? _____

Do you have any children? _____

If so, please list ages and names: _____

_____

_____

Do you adhere to any faith or religion? If so, which? _____

Current level of involvement: _____