Confidential Patient Data Form

Personal Information

Today's Date

Date Of Birth

First Name

Last Name

Cell Phone

Email

Home Phone

Work Phone

Address

Address Line 1

City

State

Zip Code

Permission to Send Email?

- [ ] Yes
- [ ] No

Emergency Contact Information

First Name

Emergency Last Name

Phone/Mobile

Relationship

Demographic Information

Gender

Ethnicity

Employer

Occupation

Education

Degrees

Relationship Status

- ○ Single
- ○ Married
- ○ Partnered
- ○ Divorced
- ○ Widow(er)

Referral Information

Your Concerns - Please Check all that apply *

- ☐ Anger Management
- ☐ Anxiety
- ☐ Career Challenges
- ☐ Coping Skills
- ☐ Depression
- ☐ Eating Habits

- [ ] Emotional Support
- [ ] Family Concerns
- [ ] Finding Purpose
- [ ] Grief
- [ ] Health Anxiety
- [ ] Identity Concerns
- [ ] Life Transitions
- [ ] Loneliness
- [ ] Managing Stress
- [ ] Mood Swings
- [ ] Parenting
- [ ] Processing Trauma Or Abuse
- [ ] Relationship
- [ ] Self Improvement
- [ ] Self-Acceptance
- [ ] Self-Esteem
- [ ] Self Harm
- [ ] Sleep Issues
- [ ] Spirituality
- [ ] Substance Use
- [ ] Triggers
- [ ] Urges to harm others
- [ ] Other

How did you hear about our practice

Health Information

Do You Currently Take Any Medications?

- [ ] Yes
- [ ] No

Have you ever been hospitalized for psychiatric reasons?
- [ ] Yes
- [ ] No

Have you ever been in psychotherapy?
- [ ] Yes
- [ ] No

What was your therapy experience?
- [ ] Positive
- [ ] Somewhat positive
- [ ] Neutral
- [ ] Somewhat negative
- [ ] Negative

Have you ever attempted suicide?
- [ ] Yes
- [ ] No

Are you currently experiencing suicidal thoughts?
- [ ] Yes
- [ ] No

Do you currently have access to a gun?
- [ ] Yes
- [ ] No

Substance Information

Have you used alcohol
- [ ] Yes
- [ ] No

Have you used Marijuana

- [ ] Yes
- [ ] No

Have you used Sedatives

- [ ] Yes
- [ ] No

Have you used Stimulants

- [ ] Yes
- [ ] No

Have you used Other Substances

- [ ] Yes
- [ ] No

Additional information you would like to provide us about your substance use?

Do you currently take prescribed medications?

- [ ] Yes
- [ ] No

Please tell us about the medications you are currently prescribed

Please Type Your Signature

Parent or Guardian Signature

Parent or Guardian Signature