Name: _____ **Date:** _____

Address: _____ **Date of Birth:** _____
Street (Apt. #, etc.)

_____
City, State, Zip

Telephone: _____ / _____
(home) (work)

Other Health Care providers (primary care doctor, insurance, etc.)

Name: _____ **Name:** _____

Phone: _____ **Phone:** _____

Current Medications: _____
(general)

_____
(psychiatric)

_____
(psychiatric)

In an emergency, please call (family member, friend, etc.):

Name: _____

Phone: _____

Name: _____

Phone: _____

Previous therapy/counseling? No ☐ Yes ☐ If yes: from (dates)

_____, _____ to _____, _____. Care was provided by (name) _____

_____ at (caretaker's office) _____.

Current difficulty: _____

_____

_____

Please write on the back of this page if you have further comments

_____
(please write above this line)

Confidential information