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Patient Information and Demographics Form

Date: _____ Referred By: _____

Patient Full Legal Name: _____

Preferred Nick Name: _____ Gender: _____ M ____ F _____N/B

Home Phone Number: _____ Other Phone Number: _____

Address: _____ Zip: _____ Email: _____

Social Security #:(optional) _____ Date of Birth: _____

Place of Employment: _____

Employer's address: _____Emp. Phone:_____

Name of insured (if different from patient): _____

Insured's Date of Birth (if different from patient):_____

Insurance Type: _____ Policy Number: _____

Phone Number to Insurance Company: _____ Group Number: _____

What is your marital status? _____ If divorced or widowed, when did this occur? _____

Who do you live with? _____

_____

Describe your living environment: _____

_____

Are your parents living? _____ Describe your relationship with them: _____

_____

_____

Why are you seeking treatment today? _____

_____

_____

Medical History:

Primary Care Physician:_____ Phone:_____

Please list any prescription medications you currently take (name, dosage, frequency):

_____

_____

Please list any over the counter medications you currently take (name, dosage, frequency):

_____

Please list any past or present medical conditions for which you have been treated: _____

_____

_____

When did you have your last physical examination? _____

Were any medical issues identified during this exam? If yes, please specify: _____

_____

Please describe any medical, psychiatric, or addiction conditions/issues of your parents or siblings: _____

_____

_____

Do you attend AA/NA or other 12 step meetings? _____ Have a sponsor? _____

Client's habits	**Amount currently using**	**Most ever used**
Coffee (cups/day)		
Cigarettes/nicotine		
Alcohol		
Non-prescription drugs		
Illegal drugs		

Please describe any abuse you have survived: ___ physical ___ sexual ___ verbal ___ rape ___ incest ___ neglect:_____

_____

_____

Describe your mood today: _____

Have you ever felt like hurting yourself? _____ If yes, did you or do you currently have a plan? _____

Have you ever been arrested? _____ If yes, please tell me what happened: _____

_____

_____

What was the outcome of your arrest (prison, probation, etc.)? _____

_____

Are you currently on probation or parole? _____ For what reason? _____

_____

Have you ever had a DUI or DWI? _____ When? _____

Do you have a religious preference? _____ Do you believe in a higher power? _____

What role does your higher power play in your life? _____

_____

Are you presently employed or in school? _____ What is your occupation? _____

Are you satisfied with your employment/school situation? _____ If no, why? _____

_____

_____

What is your highest level of education? _____

What do you like most about yourself? _____

_____

Have you ever received psychiatric or psychological treatment of any kind before? _____

If you answered yes to the above question, please answer the following:

What type of care did you receive? Inpatient (hospital) _____ Outpatient _____ Both _____

Where and when were you treated? _____

How long were you in treatment? _____

What was the diagnosis? _____

Who was your therapist or doctor? _____

Did you receive medication at the time? _____

		No	Yes	Some
1.	Do you have problems paying attention to detail or do you make careless errors?			
2.	Do you have problems staying on task?			
3.	Are you easily distracted?			
4.	Do you have problems remembering instructions?			
5.	Have difficulty organizing tasks?			
6.	Do you avoid or dislike activities that require sustained mental effort?			
7.	Do you often lose things necessary for tasks?			
8.	Do you have problems sitting for long periods of time (1 hour or more)?			
9.	Are you forgetful of daily activities?			
10.	Do you talk excessively?			
11.	Do you act without thinking?			
12.	Do others say that you interrupt or are intrusive?			
13.	Do you have a short fuse?			
14.	Do you have problems with road rage?			
15.	Are you vindictive or spiteful?			
16.	Do you hold grudges?			
17.	Are you easily annoyed?			
18.	When you are angry are you aggressive (hitting, kicking etc.)			
19.	Have you ever intentionally hurt another person?			
20.	Have you ever intentionally hurt or been cruel to an animal?			
21.	Do you get sad or irritable for no reason?			
22.	Do you have trouble falling asleep?			
23.	Do you have problems staying asleep?			
24.	Do you have recurrent nightmares?			
25.	Are you falling asleep during the day?			
26.	Do you have a loss of energy?			
27.	Have you ever been sad for longer than two weeks?			
28.	Do you have mood swings?			
29.	Do you ever feel overly excited or unusually happy for no reason?			
30.	Do you feel and look tired?			
31.	Do you excessively worry?			
32.	Are you concerned about meeting new people?			
33.	Do you worry that bad things might happen?			
34.	Do you worry that others might not like you?			
35.	Do you worry that others are against you?			
36.	Do you feel restless?			
37.	Do you have problems concentrating due to worry?			
38.	Do you have rituals or routines that you have to do?			
39.	Do you hear or see things that others don’t hear or see?			
40.	Are you easily stressed?			