Today's Date: _____/_____/_____

Patient First Name _____ Last Name _____ D.O.B. ____/____/___Age____

Address _____City _____State_____ Zip_____

Ok to email? Y / N Email _____

Ok to text? Y / N Phone _____ Circle Type: Home Work Cell Mom Dad

Additional Phone: _____ Circle Type: Home Work Cell Mom Dad

Employer (Adult) _____ Occupation _____
OR
Name of School (Student) _____ Year in School _____

Spouse Name (for Couples/Family Therapy) _____D.O.B._____

If UNDER 18 years of age:

Mother's Name _____ Cell _____ Email _____

Father's Name _____ Cell _____ Email _____

If OVER 18 years of age Emergency Contact information

Name_____ Relationship _____ Phone _____

Medical Information

Primary Care Physician or Pediatrician _____

Psychiatrist _____

Medication _____Dosage _____ Date Started _____

Medication _____Dosage _____ Date Started _____

The information above is true to the best of my knowledge:

_____ _____

Signature Date