Patient Information

Today's Date:		
Last Name:	**First Name:**	**Middle Name:**
Birth date:	**Relationship status:**	**Email:**
Names and ages of children or other dependents:	**Address:**	
Home Phone:	**Cell Phone:**	**Emergency contact:** **Phone:**
Reasons for seeking treatment:		
Referred by:		

Current Medical Conditions:	
Current Medications:	
Name and address of physician:	**Name and address of psychiatrist:**

During the last two (2) months, I have experienced:

_____ depression	_____sleep disturbance	_____racing thoughts
_____anxiety	_____eating disturbance	_____uncontrollable impulses
_____suicidal thoughts	_____panic attacks	_____flashbacks
_____relationship problems	_____difficulties at work	_____irritability
_____addiction issues	_____trouble concentrating	_____obsessive thoughts
_____legal trouble	_____memory loss or disturbance	_____disturbing dreams
_____sexual problems	_____self injuring behavior	_____my behavior worries others
_____difficulty regulating my emotions		

Previous mental health conditions for which you have sought treatment:	**Previous therapists:**

Mental health issues in extended family (parents, grandparents, children, siblings, etc.):

The above information is true to the best of my knowledge and I hereby authorize the provision of necessary psychotherapy services. I understand that the fee for these services is **$170.00** per session. I further understand that this fee is due at the end of each session, that my therapist does not accept insurance. Cancellations occurring less than **24 hours** in advance of the session will be billed.

Signature:	**Date:**