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

Do you use addictive substances (such as alcohol, nicotine, marijuana, pain medication, etc.)? _____

Do you engage in addictive behavior (excessive gambling, sex, eating, etc.)? _____

Are you involved in (or anticipate) any legal issues? _____

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 **$205** per session (unless otherwise negotiated). Extended sessions or special treatments are **$300** per session. I further understand that this fee is due at the end of each session and that my therapist does not accept insurance (though your therapist may assist you in certain ways so that you might apply for reimbursement of your costs).

Signature:	Date: