# Patient Information Form

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**Personal Information**

Name_____ Age_____ Date of Birth_____

Address_____

Home Phone_____ OK to leave message? Y N

Cell Phone_____

**Emergency Contact Information**

Name_____ Phone #_____

Relationship to Patient_____

**Insurance Information**

Subscriber Name_____

Insurance Company_____

ID Number_____

Group Number_____

Social Security Number _____

**Medical Information**

Primary Care Physician_____

Phone #_____

Please list all diseases, illnesses, significant accidents and injuries, surgeries, hospitalizations, convulsions, seizures and/or any other medical conditions you have had since childhood.

_____

_____

_____

Please list all prescribed and over the counter medications, drugs, or other substances (vitamins, herbs) you take or have taken in the last year.

_____

_____

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

Yes No

If yes, please describe:

_____

_____

Have you ever taken medications for psychiatric or emotional problems?

Yes No

If yes, please describe:

_____

_____