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PATIENT INFORMATION RECORD

Name: _____ Today's Date: _____

DOB: _____ Age: _____ SSN: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Texas Driver's License: _____

Address/State/Zip: _____

Email: _____

Employer: _____

Occupation: _____

Referred by: _____

Reason for consultation: _____

PAST HISTORY

Primary Care Physician: _____

Date of last complete physical examination: _____

Results: _____

Date of last office visit: _____

Reason and results: _____

Please list all medication allergies you have and describe the reactions: _____

Current medications (dosages, start dates and reason for use): _____

Past medications: _____

Alcohol and/or other drug use: _____ Amounts and frequency of each: _____

Tobacco and/or caffeine use: _____ Amounts and frequency of each: _____

Previous medical illnesses, surgeries, hospitalizations, locations and dates: _____

Have you seen a psychiatrist before? _____ If so, list who, when and why: _____

Psychiatric hospitalizations? _____ If so, list who, when and why: _____

Have you seen a therapist before? _____ If so, list who, when and why: _____

Which family members have had symptoms of depression, anxiety, other types of breakdowns, or substance/alcohol abuse, whether treated or not? _____

What medical illnesses run in your family? _____

Briefly describe where you were born, where you have lived, names and ages of family members, ending with your current living situation: _____

Describe any legal problems you may have: _____

What other information do you feel you should mention on this form? _____

To the best of my knowledge, the above information given by me is true and correct.

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY AGREEMENT

- I agree to pay the total amount for each session at the time services are rendered
- Because appointments have to be scheduled in advance, I agree to pay the total amount for any session not canceled or rescheduled by me at least 24 hours ahead of time
- I agree to pay a service charge of \$25 for any returned check

Signature: _____ Date: _____