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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? ☐ Yes ☐ No
If so, list who, when, and why:

Psychiatric hospitalizations? ☐ Yes ☐ No
If so, list where, when, and why:

Have you seen a therapist before? ☐ Yes ☐ No
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: _____

FEES

- Initial evaluation, average 100 minutes: $675
- Medication management, 30 minutes: $195

FINANCIAL RESPONSIBILITY AGREEMENT

- I agree to pay the above fees.
- I understand the total amount for each session is due and payable 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: _____