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New Patient Information Form

Please state name and phone number (if available) of any referring provider or agency: _____

May we thank this party for referring you? _____Yes _____ No

Name: _____

Mailing Address:_____

Email Address:_____

Phone Number(s) (your primary contact no. where messages can be left):_____

Primary Insurance Name and ID Number_____

Secondary Insurance Name and ID Number_____

Date & Place of Birth:_____

Marital Status:_____

Children (first name(s) & age):_____

Education:_____

Any religious or spiritual orientation? No__ Yes __ (please briefly describe)_____

Exercise? No__ Yes __ (please briefly describe)_____

Past & Current Employment:_____

Significant Medical/Health Issues:_____

Current Medications:_____

Past History of Counseling/Psychotherapy, Psychiatric Hospitalizations, Psychiatric Medication (please list approximate dates, type of therapy (e.g. individual, group, marital) and focus (e.g. anxiety, depression, relationship):

_____

Please state your goal(s) in seeking treatment now (be as specific as possible):

_____

_____

Signature _____

Today's Date _____