SOLACE COUNSELING

Patient Information

First Name:_____ Middle:_____ Last:_____

Maiden Name:_____ Preferred Name:_____

Address:_____ SS#_____

_____ DOB:_____

City:_____ County:_____ State:_____ Zip Code:_____

Gender:_____ Best Phone Number to reach you:_____

☐ Cell ☐ Home

Email Address:_____

Emergency Contact:_____ Their Phone Number:_____

Relationship to Patient:_____

If Patient is a minor:

Parent or Guardian's name:_____

Other parent's name and phone number:_____

Parents are: ☐ Single ☐ Married ☐ Widowed ☐ Cohabitating ☐ Divorced/Separated ☐ Remarried

If applicable, what are the custody arrangements? _____

_____

How did you hear about us?:

☐ Medical Provider_____ ☐ Therapist_____

☐ Family/Friend ☐ Insurance Company ☐ Other:_____

Are you currently seeing (or have recently seen) a therapist? ☐ Yes ☐ No

Therapist's Name and phone number:_____

Therapist's Email and/or fax number:_____

Relationship Status:

☐ Single ☐ Married ☐ Cohabiting ☐ Divorced/Separated ☐ Other:_____

Partner's Name:_____

General Medical Information:

Do you have, or have you ever had, any of the following medical conditions?

☐ Asthma ☐ High Blood Pressure ☐ Seizures ☐ Liver Damage ☐ Kidney Problems ☐ Sleep Apnea
☐ Cardiac Problems:_____ ☐ Chronic Pain/Fibromyalgia ☐ Thyroid Disease
☐ Head Injury/Concussion ☐ Gastric Surgery ☐ Other:_____

Please list any medications you are currently taking for your physical health related problems:(Include over-the-counter & herbals):

_____

_____

Is there any possibility you could be pregnant? ☐ Yes ☐ No

Mental Health History:

What are the problems for which you are seeking help?_____

_____

Date your current mental health symptoms started:_____

Have you ever been treated for any of the following (check all that apply):

☐ Depression ☐ Anxiety ☐ Panic Attacks ☐ PTSD ☐ Anorexia/Bulimia ☐ Binge Eating ☐ ADHD
☐ Bipolar (Manic/Depressive) ☐ Schizophrenia/Schizoaffective Disorder ☐ Autism/Asperger's ☐ OCD
☐ Borderline Personality ☐ Drug or Alcohol Problems ☐ Other:_____

Please list all prior psychiatric hospitalizations, if any (Including IOP, PHP, or other outpatient programs)

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

_____ _____

Print Patient Name Date