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Patient Information Sheet

NAME:_____
ADDRESS:_____
May I have permission to mail to this address? YES_____NO_____
PHONE(home):_____
PHONE(work):_____
PHONE(cell):_____
Which number do you prefer I call? Home_____Work_____Cell_____
FAX:_____
EMAIL ADDRESS:_____
BIRTHDAY_____
Others living at home:_____
Employer_____Occupation_____
How long have you worked there?___How long in this occupation_____
Education: (List highest level of education attained)_____
Primary Physician:_____Phone:_____
List any significant health problems:_____

List any medications you are taking and the dose:_____

Have you seen a therapist before? YES_____NO_____
If yes, when and with whom?_____
Please give a brief description of treatment:_____

Was the experience a positive one?

If you are comfortable, please briefly describe your reason for seeking treatment at this time

_____
_____
_____
_____

Do you have any clear goals that you would like to achieve during therapy?_____
_____
_____
_____
_____

How were you referred to me?__

Diablo Magazine _____
Web search _____
Doctor referral _____
Friend referral _____
Other, please explain

IN CASE OF EMERGENCY:

NAME:_____

ADDRESS:_____

NUMBER_____