Today's Date: _____

Patient Information

Name_____ Age: _____ Date of Birth:_____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____
Cell Phone _____
Occupation _____
Employer Name _____Work Phone _____
Work Address _____

Marital Status: ___Married ___Separated ___Divorced ___Never Married

Children? ___ Yes ___No
If so, names and ages _____
_____

Referred By

Name _____ Relationship _____
Address_____ Telephone_____
City_____ State_____ Zip Code_____

Emergency Contact

Name _____ Relationship _____
Address_____ Telephone_____
City_____ State_____ Zip Code_____

Reason for Visit

What is the primary reason for your visit today?

_____
_____
_____

What would you like help with?

_____
_____
_____

Today's Date: _____

Health History

Primary Care Physician _____
Address _____ Telephone _____
City _____ State _____ Zip Code _____

Height _____ Weight _____ Date of Last Physical _____

Please describe your physical health

_____
_____
_____
_____

List any chronic illnesses

_____
_____
_____
_____

List any surgeries

_____
_____
_____
_____

Do you drink alcohol? Yes ____ No ____
If yes, how much?
How often to you drink?

Do you use other substances? Yes ____ No ____
If yes, what substances?
How often?

What activities do you do for relaxation, recreation or fun?

_____
_____
_____
_____

Today's Date: _____

Education

Please list the schools you have attended with the diploma or degrees you have received.

Name of School or College	City, State	Diploma / Degree	Major	Years Attended
College / Post High School				
High School				
Middle School / Jr. High				
Elementary				
Preschool				

Work History

Please list the jobs you have held since high school.

Employer	When?	Job Title	Job Responsibilities