Patient Questionnaire

Information provided on this form is confidential.

Name: _____ Date of Birth: _____

Preferred Name: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ OK to leave a message: ☐ YES ☐ NO

Email address: _____

Relationship Status: _____ Name of Partner: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Current employment: _____

Highest education level: _____

Primary care physician: _____ Date of last exam: _____

Current medical conditions: _____

_____

_____

Current medications: _____

_____

_____

Previous mental health treatment with dates: _____

_____

_____