

Health Care Information

Primary Care Physician:

Last Seen: _____ Reason: _____

Current Health Problems: _____

Current Medications: _____

Previous Psychological / Psychiatric / Chemical Dependency Assistance:

Therapist *Reason* *Year Began* *How Long*

You: _____

Your Partner: _____

Previous Psychiatric Hospitalization: _____

Circle One:

Ever thought you may have a drinking or drug problem? Yes / No Been told? Yes / No

Ever thought you may have a problem with food/eating? Yes / No Been told? Yes / No

Have you ever really considered, or attempted suicide/homicide? Yes / No

Fees Associated with Treatment will be paid by:

Name: _____ Phone: (____) _____

Address (If different): _____

In Case of Emergency Call:

Home Phone (____) _____ Work Phone (____) _____ Ext. _____

I hereby request and give consent to receive psychotherapy from Dr. Patrick B. McGinnis, PhD, LMHC.

Signature

Date

Previous Significant Relationships

First Name	Began	Ended	How long together	How long apart	Why did it end?

Your Education:

Grade School _____ High School _____ College _____ Graduate Study _____

If College, Your Major: _____

Religion:

Yours _____ Active _____ Inactive _____

Your Partner _____ Active _____ Inactive _____

Family Members

Identify all persons who are your children, for whom you assume personal or family responsibility, or other persons who live with you.

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Place an asterisk () next to those who live with you.*

Welcome to my office. Your cooperation in completing these forms will enable me to provide you with the most appropriate assistance.

(Please feel free to write on the back of these pages if you need additional space for any item.)

Personal Information

Name _____
First Middle Initial Last

Birth date _____ Age _____ Sex _____

Address

Street Apt. #

City State Zip Code

At times I send information about current services to your home or email address. If you prefer not to receive mail, please check this box: []

Home Phone (____) _____ Work Phone (____) _____ Ext.

Email Address _____

Who referred you to me? _____ May I thank them? Yes [] No []

Social Security Number _____ - _____ - _____

Your place of employment _____

Your position or title _____

How long have you worked there? _____

Current Relationship (Check as Appropriate)

Single? ___ Married? ___ Live Together? ___ Involved and Live Apart? ___ How long? ___

Your Partner's Name _____ Age _____

Your Partner's Place of Empl. _____

Your Partner's Occupation _____

Your Partner's Phone (____) _____ Ext. _____ (Home? ___ Or Work ___?)