Name ____ **Date** __________________________

DOB ___________________ Age _____ Gender _______ (SSN if Medicaid or Tricare Insured) ______________________________

Address ____

Phone (Cell) ____ (Home) ____

Email ____

Occupation ____________________________________ Employer/School _____________________________________

Emergency Contact 1 ____ Relationship________________________________

Phone (Cell)____ (Home) ____

Address ____

Emergency Contact 2 ____ Relationship_______________________________

Phone (Cell) ____ (Home) ____

Health: Date of last full health check and lab ____

Medical Provider____ Phone ____________________________

Address ____

Psychiatrist ____ Phone ____________________________

Current/last MH therapist or agency ____

Address ____Phone ____________________________

Psychiatric Rx + Supplements ____

____

Health concerns ____

Mental Health diagnosed conditions ____

Treatment type & dates ____

Allergies ____

Billing: Self ____ Medicare ____ Medicaid ____ Insurance Provider____

Paying person's name (if not the patient)____

Referral Source: ____

____ ____

Signature **Date**

Hrs available for appts, am: Mon ________; Tue ________; Wed ________; Thu ________; Fri ________; Sat ______; Sun ______;

pm: ________; ________; ________; ________; ________;