

Date \_\_\_\_\_

**PERSONAL DATA**

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Birth date \_\_\_\_\_

Phone \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Source of support if not employed: \_\_\_\_\_

Spouse's Name (or parent if under 18) \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

By whom referred: \_\_\_\_\_

Previous therapy: \_\_\_\_\_

Psychiatric hospitalizations: \_\_\_\_\_

**HAVE YOU HAD OR DO YOU NOW HAVE:**

Hereditary diseases: \_\_\_\_\_

Cancer: \_\_\_\_\_

Heart Diseases: \_\_\_\_\_

Diabetes or Hypoglycemia: \_\_\_\_\_

Broken bones: \_\_\_\_\_

Sleep disruption: \_\_\_\_\_

Allergies: \_\_\_\_\_

Chronic problems: \_\_\_\_\_

**PLEASE GIVE INFORMATION REGARDING:**

Alcohol consumption: \_\_\_\_\_

Tobacco use: \_\_\_\_\_

Medication/drugs you are taking: \_\_\_\_\_

Diet: \_\_\_\_\_

Exercise: \_\_\_\_\_

Last Physical: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

**REASONS FOR MAKING APPOINTMENT:**