

Patient Information

Patient Name _____

Date of Birth _____

Occupation _____

Medication _____

Primary Care Physician and/or Psychiatrist Name _____

Phone Number _____

Brief reason for seeking counseling at this time:

Marital Status: Married___ Divorced_____ Widowed___ Single___

Children: Number_____ Ages_____

Medical History: Briefly report any illness, surgeries and for women regular or irregular cycles

Generally, growing up I felt:

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