

## NEW PATIENT INFORMATION SHEET

Completing this form may save us some time in our therapy session. However, all of the information requested is completely voluntary. Leave blank any item you do not wish to answer.

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip Code

### Phone Numbers:

Home: \_\_\_\_\_  Message ok  Discrete message only  No messages

Office: \_\_\_\_\_  Message ok  Discrete message only  No messages

Mobile: \_\_\_\_\_  Message ok  Discrete message only  No messages

Date of birth: \_\_\_\_\_ Age: \_\_\_\_

Relationship Status:  married or living with romantic partner  
 single, never married  
 divorced/separated  
 widowed

Number of Children:  biological  adopted  step

Current/chronic illnesses (e.g., hypothyroidism; arthritis; diabetes; hypertension; epilepsy):

Current medications (prescription, over the counter, and herbal remedies; name & dose):

Past major illnesses/surgeries (e.g., heart attack; cancer; hysterectomy):

Date of last physical examination: \_\_\_\_\_

Current exercise habits:

Average number of caffeinated beverages per day: \_\_\_\_ Average hours of sleep per night: \_\_\_\_

Current alcohol use: Average # days/week = \_\_\_\_ Average # of drinks when I do drink = \_\_\_\_

Other drugs (e.g., marijuana, cocaine) I currently use: