Your Name: _____ **Date of Birth:** _____

Please complete this form prior to your first visit and present to the front desk when you check in. *If you need additional room, please use the back of this form.*

Have you ever seen a psychiatrist or psychotherapist before? If so, please list prior practitioners:

Name	Address	Phone and Fax

Please list in chronological order all prior psychiatric hospitalizations (if any) over the previous 3 years:

Approx. Date	Length of Stay	Name of Hospital	Reason for Admission

For any hospitalizations listed above, please provide contact information:

Hospital Name: _____

Mailing Address/City/State/Zip: _____

Telephone: _____ Fax: _____

Hospital Name: _____

Mailing Address/City/State/Zip: _____

Telephone: _____ Fax: _____

Hospital Name: _____

Mailing Address/City/State/Zip: _____

Telephone: _____ Fax: _____

CURRENT PROVIDERS

Primary Care Physician: _____ **Practice Name:** _____

Address/City/State/Zip: _____

Telephone: _____ Fax: _____

Therapist: _____

Address/City/State/Zip: _____

Telephone: _____ Fax: _____

Other Provider Name/Relationship: _____

Address/City/State/Zip: _____

Telephone: _____ Fax: _____

PHARMACY *(You are welcome to use our onsite pharmacy. Please ask for details.)*

Name: _____

Address/City/State/Zip: _____

Telephone: _____ Fax: _____

EMERGENCY CONTACT

Name/Relationship: _____

Address/City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SCHOOL CONTACT *(for students)*

Name: _____

Address/City/State/Zip: _____

Telephone: _____ Fax: _____