Physician & Healthcare
CONSULTING, LLC

PATIENT INFORMATION FORM

Patient Information

Date__________________

First Name: ______________________ MI____ Last Name:_______________________ Sex: ☐ M ☐ F ☐ X

Nickname or Preferred Name: ____

Address:_____________________________________ City:_________________ State:_____ Zip:_____________

Cell Phone: ______________________________

Date of Birth: _______________ Marital Status: ________________ Ethnicity: _____________________

Emergency Contact: ______________________ Relationship: ________________ Phone: ______________

Adopted: ☐ YES ☐ NO In Foster Care While Growing Up: ☐ YES ☐ NO ☐ Currently

Relationship Status: ☐ Single ☐ Dating ☐ Live-in Partner ☐ Domestic Partner ☐ Married

☐ Separated ☐ Divorced ☐ Widowed (Year) _______________

Sexual Orientation: ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Trans ☐ Pansexual

Preferred Pronouns: ☐ He/Him ☐ They/Them ☐ She/Her

Parents Information if Patient is a Minor

☐ **Biological** ☐ **Adopted** ☐ **Guardian** ☐ **Stepparent Name 1:** _________________________________

Address is same as above: ☐ YES ☐ NO

Address if different: :_________________________ City:_________________ State:_____ Zip: _____________

Cell Phone: ________________

☐ **Biological** ☐ **Adopted** ☐ **Guardian** ☐ **Stepparent Name 2:** _________________________________

Address is same as above: ☐ YES ☐ NO

Address if different: :_________________________ City:_________________ State:_____ Zip: _____________

Cell Phone: ________________

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Insurance Information **Copay for each appointment: ______________**

Name of Insurance Company:____

Address of Insurance Company: ____

Phone # Listed on Card: ____

Name of Responsible (Subscriber) Insured Person: ______________________________________

Employer: ____

Responsible Person DOB: ______________________ SSN: ________________________________

Member Name & Number if Different:____

Member Number: __________________________________ Group Number:_______________________

Communication Preference (check all that apply)

☐ I wish to be contacted using ______________________________ phone number to leave reminders and voice messages on.

☐ I wish to be contacted using ______________________________ phone number to leave reminders and messages via text messages on.

☐ I wish to be contacted using ______________________________ email to write reminders, messages, or to send educational information.

Who else resides in the home with you? (Name, Age, Relationship)

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

What is the problem(s) or concern(s) you are seeking help for?

1. ____
2. ____
3. ____

How motivated are you to address the problems? **0** (no motivation) **to 10** (100% motivation) ____________________

What do you consider to be some of your strengths?

______________________________ ______________________________ ______________________________

What is one or two ways that you cope when things get difficult? ____

____

List all medications, over-the counter medications, including vitamins and supplements that you take daily. This includes marijuana, CBD supplements, tinctures, lotions, etc …			
Name of Medication / Start date	**Dosage**	**Prescriber Name**	**Has it helped? Any problems with it?**

Personal and Family History (Mark as many as apply)

	You	Family - Which	Additional Info?
Thyroid Disease			
Anemia (iron deficiency)			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Diabetes			
Asthma/Respiratory			
Stomach/Intestinal			
Cancer			
Fibromyalgia			
Heart Disease			
Epilepsy/Seizures			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Head Trauma			
Sleep Issues			
Obesity			
Depression			
Bipolar			
Generalized Anxiety			
Social Anxiety			
Separation Anxiety			
Eating Disorder			
Panic Attacks			
Phobia			
PTSD			
ADHD/ADD			

OCD			
Tourette's			
Psychosis			
Alcohol Abuse			
Substance Abuse			
Died by Suicide			
Other: Name			

Do you have any concerns about possible medical issues currently? ☐ YES ☐ NO

If YES, please describe: ____

Name of Primary Care Provider: ____

Name of Clinic & Address, Phone:____

Name of Psychiatrist:____

Name of Clinic & Address, Phone:____

Name of Neurologist:____

Name of Clinic & Address, Phone:____

☐ **Please note that as a Health Psychologist I prefer to work in consultation with Primary Care & Specialty Providers (Psychiatrist, Neurologist, Oncologist, etc.) who are also involved in your care. Please complete the **Release of Information** so that I may review labs, medical diagnoses, and any current issues in your medical chart that may also contribute to mental health so I may best serve you.

☐ If you would like me to share my notes with any of the providers listed. Please complete the **Release of Information Form.**

Educational History:

Highest grade completed in middle/high school? ___________ Where?___________________________

Did you graduate? ☐ YES ☐ NO ☐ Not Yet GPA:_______________

Did you attend college? ☐ YES, Currently Attending ☐ YES ☐ NO ☐ Not Yet
If YES, Major?_____________________________

Did you graduate? ☐ YES ☐ NO ☐ Not Yet GPA:_______________

Was school … ☐ Easy ☐ Somewhat Easy ☐ In the Middle ☐ Somewhat Difficult ☐ Difficult

Employment:

Are you currently employed? ☐ YES ☐ NO ☐ N/A If NO, how long unemployed? ___________________

If YES, Is your employment stable? ☐ YES ☐ NO ☐ N/A How long at the company? _____________

Company Name: ___________________________________ Position: _____________________________

Is employment related to why you are seeking care? ☐ YES ☐ NO ☐ Sort of

Explain: ____

Housing:

Do you have stable housing? ☐ YES ☐ NO

☐ Rent ☐ Own ☐ Live with parents ☐ Live with friends ☐ Foster care

☐ Homeless in Shelter/Outside ☐ Homeless Couch Surfing ☐ Other: _______________________________

Anything else I should know before your appointment?

____

____

____

____

Patient Signature (13+): ____ Date: __________________

Guardian Signature (less than 13 years): ___________________________ Date: __________________