Patient Information

Please provide the following information below. All information will be kept confidential. If there are questions that you do not wish to answer at this time, feel free to leave them blank.

Name: _____
(Last) (First) (Middle initial)

Name of parent or guardian (if under 15 years old):

_____
(Last) (First) (Middle initial)

Age: _____ Birthdate: _____ Gender: _____

Marital Status: ___Never Married ___Married ___Divorced ___Separated ___Widowed
___Domestic Partnership

Please list any children and ages: _____

Home Address: _____
(Street Number)

_____
(City) (State) (Zip Code)

Home Phone: _____ Okay to leave a message? ___Yes ___No

Cell/Other Phone: _____ Okay to leave a message? ___Yes ___No

Email: _____ Okay to leave a message? ___Yes ___No
Please note that email is not always considered confidential

How did you find out about Dr. Stephanie King? _____
May I thank this person for the referral? ____ Yes ____ No
Referred by (if any): _____

Emergency Contact: _____
(Name) (Relation) (Phone #)

Have you previously received any type of mental health services, such as counseling, psychiatric services or hospitalizations? ___No ___Yes If yes, please provide additional information below:
Name:_____ Phone:_____
Name:_____ Phone:_____
Name:_____ Phone:_____
Name:_____ Phone:_____

Health and Medical

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

_____

_____

_____

_____

How would you describe your current physical health? (Circle one)

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

_____

_____

_____

_____

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

_____

_____

_____

_____

From the following list, please check any items that you have experienced recently:

____Loss of interest in previously enjoyed activities
____Overwhelming sadness
____Crying often
____Feeling hopeless
____Overwhelming anxiety
____Overwhelming panic
____Overwhelming worry
____Frequent physical complaints (headaches, etc.)
____Significant change in weight
____Trouble falling asleep or staying asleep at night
____Racing thought patterns
____Disorganized thought patterns
____Thoughts of suicide
____Irritability or anger
____Mood shifts
____Self-Mutilation
____Sexual concerns
____Physical abuse
____Sexual abuse
____Emotional abuse
____Explosive temper
____Excessive energy
____Conflicts with friends
____Conflicts with family
____Conflicts with coworkers
____Disturbing dreams
____Difficulty saying no to others
____Uncomfortable in social situations
____Overindulgence in alcohol
____Overindulgence in recreational drugs
____Overindulgence in sexual activity

Family History

Please list any medical conditions (both physical and mental health) that exist within your family, as well as the family member with the condition:

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

Is there any history of suicide in your family? If so, please list:

Do you have any siblings? If so, please list with ages:

Who do you turn to for support in your family?

Occupational and Social

Are you currently employed? ____Yes ____No

If yes, what is your current occupation? _____

Do you enjoy your current profession? ____Yes ____No

If no, what would you change? _____

Please list any current legal troubles at this time, if any:

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

What do you view to be your strengths as a person?

Briefly describe what has brought you to therapy at this time.