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PATIENT INFORMATION SHEET

NAME____ SEX: M__ F__ DATE__________

HOME ADDRESS_________________________________EMAIL____________________________

CITY____STATE_______ZIP_________________

PHONE: HOME___________________ CELL_____________________ WORK____________________

BIRTH DATE___/___/___ AGE_____MARRIED__DIVORCED__WIDOWED__COHABITING__ REMARRIED__

EMPLOYER_______________________WORK ADDRESS____________________________________

NUMBER OF CHILDREN__BOYS__GIRLS__NAMES AND AGES_________________________________

OTHERS IN THE HOME_____________________________________REFERRED BY_______________

ANY SIGNIFICANT MEDICAL PROBLEMS IN THE FAMILY? ___________________________________

ARE YOU UNDER MEDICAL TREATMENT?

____EXPLAIN______________________________________

DOCTORS (NAMES, SPECIALTY AND PHONE #'S): ____

____

____

PREVIOUS THERAPY? (WHERE, WHEN, THERAPIST) _______________________________________

____

EDUCATION: H.S.______________________________________YEAR GRADUATED______________

COLLEGE/UNIVERSITY____________________DEGREES(S)____________YEAR GRADUATED______

RESPONSIBLE PARTY, SPOUSE, OR SIGNIFICANT OTHER

NAME_____________________________________RELATIONSHIP___________________________

HOME ADDRESS____

CITY____STATE________ZIP____________________

PHONE: HOME____________________CELL______________________WORK___________________

EMPLOYER__________________WORK ADDRESS____

RELATIVE OR FRIEND NOT LIVING WITH YOU

NAME_____________________________________RELATIONSHIP___________________________

HOME ADDRESS____

CITY____STATE________ZIP____________________

PHONE: HOME____________________CELL______________________WORK___________________