



NEW PATIENT INFORMATION SHEET

PATIENT:

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

FOR PATIENTS UNDER AGE 18:

MOTHER'S NAME: _____ AGE: _____ BIRTHDATE: _____

FATHER'S NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: (M) _____ (D) _____

EMAIL: (M) _____ (D) _____

CELL: (M) _____ (D) _____

MARITAL STATUS OF PARENTS: Married Separated Divorced* Widowed

*If Divorced: Custody: _____

Visitation: _____

Child's Main Residence: _____

Divorce Agreement: _____

DOES PATIENT HAVE HISTORY OF...OR IS THERE ANY FAMILY HISTORY OF? (PLEASE YES
BIPOLAR DISORDER OR MANIC-DEPRESSION:

YES

NO

NOTE RELATIONSHIP TO PATIENT):

DEPRESSION:

NO