Sacramento
CENTER FOR PSYCHOTHERAPY

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Date _____

Client Information

Name_____ Phone: Home _____
Address _____ Work _____
_____ Cell _____
Birth date _____ Best number to call: H W C Message: Yes No (circle)

Employer _____ Occupation _____
Work address _____
Medical Insurance _____ ID # _____

Referred by _____ May I thank the referral source? Yes No

In case of emergency contact: Name _____Phone _____
Relationship to you _____

Others living in your home:
Name _____ Relationship to you _____
_____ _____
_____ _____
_____ _____

Previous mental health treatment? Yes No (circle one)
Provider name(s) _____ Dates_____
_____ _____
_____ _____
Physician _____ Phone _____
_____ Date of last exam _____
_____

Significant medical problems: _____
_____
_____
_____

Allergies: _____

Current Medications: (use extra sheet if needed)

Medication	Dosage	Starting date	Purpose	Prescribing physician

Family Medical and Psychiatric History (use extra sheet if necessary)

	First name	Age/Year Of birth	Medical History	Psychiatric History - include medications
Mother				
Father				
Sibling				
Sibling				
Sibling				
Spouse/ Partner				
Child				
Child				
Child				