TACONIC COUNSELING GROUP

Counseling and Psychotherapy for Children, Adolescents, and Adults

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Patient Information Form

Today's Date: ___/___/___

Patient Information

Name: _____
Address: _____
City: _____
State: _____ **Zip code:** _____

Marital Status: ☐ Single ☐ Married ☐ Other
Home Phone: ( ) ___-____
Work Phone: ( ) ___-____
Cell Phone: ( ) ___-____
Social Security # ___-__-____

Date of Birth: ___/___/___ **e-mail:** _____ **Do you check your e-mail daily? Yes** ☐ **No** ☐

Sex: ☐ Male ☐ Female **Employment Status:** ☐ Employed ☐ Full time Student ☐ Part Time Student

Responsible Party (If other than patient)

Name: _____
Address: _____
City: _____
State: _____ **Zip code:** _____

Home Phone: ( ) ___-____
Work Phone: ( ) ___-____
Social Security # ___-__-____

Marital Status: ☐ Single ☐ Married ☐ Other **Sex:** ☐ Male ☐ Female

What is your relationship to the patient? ☐ Spouse ☐ Child ☐ Self ☐ Other _____

Spouse Information

Name: _____ **Home Phone:** ( ) ___-____
Work Phone: ( ) ___-____

Emergency Contact

Name: _____ **Home Phone:** ( ) ___-____
Work Phone: ( ) ___-____

Over

Physical Health Information

Physician name: _____ **Physician Phone:** ( ) ___-____

Do you have any health problems? ☐ Yes ☐ No

List: _____

Are you currently taking any medication? ☐ Yes ☐ No

List: _____

Other Information

Are you currently involved, or or planning to be involved in any legal proceedings? ☐ Yes ☐ No

Nature of the proceedings: _____

By whom were you referred? _____

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Please answer the questions below:

1. JOB CATEGORY

- ☐ MANAGEMENT
- ☐ SERVICE
- ☐ PROFESSIONAL
- ☐ SALES
- ☐ TECHNICAL
- ☐ OPERATIONS
- ☐ HOMEMAKER
- ☐ CLERICAL / ADMINISTRATIVE
- ☐ INDUSTRIAL
- ☐ MAINTENANCE
- ☐ UNEMPLOYED
- ☐ RETIRED

Tell us in more detail: _____

2. WERE YOU WORKING IN THE LAST MONTH? ☐ YES ☐ NO ☐ Full Time ☐ Part Time ☐☐.☐ Hours/Week

3. MARITAL STATUS

- ☐ SINGLE
- ☐ MARRIED
- ☐ WIDOWED
- ☐ SEPARATED / DIVORCED

4. WERE YOU IN SCHOOL THE LAST MONTH? ☐ YES ☐ NO ☐☐ Units/Week

5. HIGHEST GRADE COMPLETED IN SCHOOL

- ☐ 8TH GRADE OR LESS
- ☐ SOME HIGH SCHOOL
- ☐ HIGH SCHOOL GRAD / GED
- ☐ SOME COLLEGE
- ☐ ASSOCIATES DEGREE
- ☐ BACHELORS DEGREE
- ☐ MASTERS DEGREE
- ☐ PhD / MD

6. WHAT WAS YOUR USUAL LIVING ARRANGEMENT IN THE LAST YEAR?

- ☐ WITH PARENTS
- ☐ W/ SPOUSE & / OR CHILDREN
- ☐ WITH FRIENDS
- ☐ ALONE
- ☐ DORMITORY
- ☐ OTHER

7. HOW MANY MEDICAL VISITS HAVE YOU HAD IN THE LAST YEAR? ☐ 0-5 ☐ 6-20 ☐ 21-40 ☐ 41+

8. HAVE YOU HAD PRIOR:

VISITS TO A MENTAL HEALTH THERAPIST? ☐ YES ☐ NO Year(s): ☐☐☐☐ TO ☐☐☐☐

With Whom?: _____

PSYCHIATRIC HOSPITALIZATIONS? ☐ YES ☐ NO Year(s): ☐☐☐☐ TO ☐☐☐☐