CA PSYCHOLOGY

FACE SHEET

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Parent(s)/Legal Guardian(s) Name (*if patient is a minor*): _____

_____

Address: _____

Street *City* *Zip Code*

Contact Number

Primary: _____ Secondary: _____

PATIENTS MARITAL STATUS:

___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone Number: _____

REASON FOR SEEKING THERAPY (*briefly describe*): _____

_____

_____

How did you hear about CA Psychology, LLC? _____

MEDICAL INFORMATION:

Name of Primary Care Physician: _____ Date of Last Physical: _____

Medical Conditions: _____

Current Medications: _____

Current Supplements: _____

MENTAL HEALTH HISTORY:

Have you met with a psychologist in the past? ___ Yes ___ No

Did you find therapy helpful? ___ Yes ___ No

If you answered yes to the above, please provide the name(s) of the provider(s), the approximate treatment date(s), and any previous diagnoses:

_____

_____

CLIENT ID _____

Have you ever been hospitalized for a psychiatric diagnosis? ___ Yes ___ No
If so, when & where?

_____

_____

Is there a family history of any psychiatric disorder(s)? ___ Yes ___ No
If so, please share which diagnoses and family member(s)?

_____

_____