GINGER M. SULLIVAN

INDIVIDUAL, COUPLE & GROUP PSYCHOTHERAPY

Patient Information Form

(To be completed by all individual and group therapy patients)

Please provide the information in the spaces below. All information is strictly confidential and will not be shared with anyone without your written consent.

Date: _____
Name: _____
Address/City/State/Zip: _____
_____
Cell Phone: _____
Work Phone: _____
Email Address: _____
Birthdate: _____
Age: _____
Marital Status: _____
Social Security #: _____
With whom do you reside? _____

Employer: _____
Work Address/City/State/Zip:
_____
_____
How Long Employed Here? _____
Position: _____

Person to Notify In Case of an Emergency: _____
Address/City/State/Zip: _____
Phone: _____

What previous therapy have you had and when?

_____
_____
_____

What medication are you currently taking – prescription and otherwise?

_____
_____

Name and phone number of prescribing physician?

_____
_____

List the major problem areas that bring you to therapy:

_____
_____
_____

To whom may we thank for referring you to our practice? _____

Thank you!