



3069 S. Broad St., Suite 7d, Chattanooga, TN 37408 / 423.3238.8783

Confidential Information - Adult

(Please Print)

Name _____ Today's Date _____
first middle or maiden last

Age _____ Date of Birth _____ Sex: Male Female Education _____

Home Address _____
street city state zip

Home Phone _____ Email _____

Work Phone _____ Employer _____

Work Address _____
street city state zip

Please circle any addresses, phone numbers or e-mails that you DO NOT want me using to reach you OR leaving a message. I do not want to compromise your confidentiality or create an uncomfortable situation.

Marital Status _____ Date of present marriage _____ Date(s) of previous marriage(s) _____

Spouse's name _____ Age _____ Education _____

Spouse's occupation _____ Employer _____

Other Family Members Place a check beside the name(s) of those with whom you now live. Circle (M)ale or (F)emale.

Spouse _____	Age _____		Your Father _____	Age _____
Child(ren): _____	Age _____	M/F	Your Mother _____	Age _____
_____	Age _____	M/F	Brothers/Sisters: _____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F
_____	Age _____	M/F	_____	Age _____ M/F

Former-Spouse _____ Age _____ Marital Status: S / REM / Div Years _____

Physician / Internist / Gynecologist / Psychiatrist / Etc. (Doctor(s) seen routinely):

[1] Name _____ Ph. () _____ Years _____

Address _____ City _____ State _____ Zip _____

[2] Name _____ Ph. () _____ Years _____

Address _____ City _____ State _____ Zip _____

Do you have any current or ongoing medical problems? Please explain:

CURRENT MEDICATIONS: Taken as prescribed?

<u>Medication</u>	<u>Dosage</u>	<u>Yes</u>	<u>No</u>	<u>Doctor</u>	<u>Reason</u>	<u>How Long?</u>
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

Do you smoke? Yes No If so, how much? _____ How long? _____

Previous Mental Health Services:

<u>Provider</u>	<u>Location</u>	<u>Dates of Service</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current or expected legal involvement? Yes No If yes, please explain: _____

Current Order of Protection or Restraining Order? Yes No If yes, please explain ~ _____

Referred by: _____ **Phone:** _____

Address: _____ street _____ city _____ state _____ zip _____

May I contact this person/agency to notify them of your follow through for an appointment? Yes No **Initials:** _____

Person to notify in case of emergency: _____ **Relationship:** _____

Address: _____ street _____ city _____ state _____ zip _____ **Phone:** _____ home _____ work _____

Religious affiliation: _____

List your leisure interests and activities:

What do you consider to be your strengths?

Briefly describe the concerns and reasons that brought you here:

Briefly list your goals for treatment here; that is, what you would like to achieve and/or see happen by coming here for care: