

RED MOUNTAIN COUNSELING, P.C

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(571) 594-3338

PATIENT INFORMATION FORM

(Please note that all information is confidential within the bounds of legal limitations)

Name: _____ Birth Date _____

Address: _____

May I mail to you at this address? ___ Yes ___ No

Work phone: _____ May I contact you at this number? ___ Yes ___ No

Home phone: _____ May I contact you at this number? ___ Yes ___ No

Cell Phone: _____ May I contact you at this number? ___ Yes ___ No

email: _____ May I email you? ___ Yes ___ No

Family composition:
(Include age & gender of children)

Marital Status: Single Married Divorced Separated Widowed

Others living in the home:

Are you seeking counseling services for: SELF CHILD FAMILY COUPLE

How were you referred to this counseling practice? _____

Who may I thank for referring you? _____

Can you identify an event or crisis that brought you to seek counseling?

Could you identify any physical or emotional symptoms related to this event?

Are you currently under the care of a mental health professional? ___ Yes ___ No
(All information is held confidential within the bounds of legal limitations)

Are you presently on medication prescribed by a physician? ___ Yes ___ No

If yes, please list the medication(s) and why they are prescribed:

Do you have any health issues that your counselor should be aware of or that concern you? Yes No

What is the primary outcome you seek from counseling services?

(On the back) Please provide any other information that you feel may give me additional insight into how counseling services can be helpful to you.

Thank you
Please do not hesitate to contact me during normal business hours.