New Client Information

Name: ____Date of Birth:__________

Home Address: ____

City: __________________________________State: _____Zip: ____________

Home:_________________Cell:_______________Work:___________________
Please indicate if I can leave a message at any of these numbers. Home: *yes/no* Cell: *yes/no* Work: *yes/no*

*E-mail Address:____

☐**Please do not contact me by e-mail. *E-mail is not confidential and therefore used infrequently.**

Driver's License #________________________State:____________Exp._______

Emergency Contact: ________________________________Phone: __________

--------------Person Responsible for Payment If Different From Above. -----------

Name: ____

Home Address: ____

City: __________________________________State: ______Zip: ____________

Home:_________________Cell:_______________Work:___________________

*E-mail Address:____

I give my permission to Tamela Dreyer to release billing information to the person named above. I understand that I am ultimately responsible for any unpaid balance.

______________________________ ____________________________

Signature Date Print Name

Medical Information

Primary Care Physician: ____________________________Phone: ___________

Psychiatrist: ____Phone: ____________

Current Medications:____

____

____

Have you ever been hospitalized for a psychiatric condition?   Yes____ No______

If yes, describe dates and circumstances:___________________________________

____

____

____

____

____

Medical conditions/concerns:____

____

____

Surgeries:____

Allergies:____

General physical health is: ☐Excellent   ☐ Good   ☐Fair   ☐Poor

Treatment Information

Referred by: ____

May I thank them for the referral?   ▫Yes   ▫No

Reason for your visit:____

Desired outcome of treatment:______________________________________

Past therapy experiences: (Please comment on past reasons for treatment, length of treatment, if it was helpful or a negative experience.)