Patient Information Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first appointment.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

How did you find my practice?_____

Have you previously received any type of mental health services?

□ No
□ Yes, previous provider: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

Have you ever been prescribed psychiatric medication?

□ Yes
□ No

Please list and provide dates: _____

_____

PHYSICAL AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are experiencing:

2. Are you experiencing any sexual health difficulties?
□ No
□ Yes

If yes, please check any that are problematic at this time:

___ Erectile Dysfunction (trouble achieving or maintain erections)

___ Premature Ejaculation (reaching orgasm more quickly than you would like)

___ Unable to Achieve Orgasm

___ Compulsive Sexual Behavior/Sexual Addiction

___ Internet Pornography/Cybersex Addiction (excessive time on computer for sexual release)

___ Reduced Sexual Desire

___ Loss of Attraction to my Partner

___ Pain with Sexual Activity

3. Are you currently experiencing any challenges with attention deficit disorder/concentration difficulties?

□ No
□ Yes
If yes, when did you begin experiencing this? _____

4. Are you currently experiencing any mood changes, depression or anxiety?
□ No
□ Yes

If yes, please describe:

5. Do you drink alcohol more than twice per week? □ No □ Yes

6. What significant life changes or stressful events have you experienced recently?

Please describe:

7. Are you currently employed? □ No □ Yes

If yes, describe your position:

Do you enjoy your work? Is there anything stressful about your work life?

8. Please describe your main goals for treatment and how you would like me to assist you with them:

Goal#1:

Goal#2:

Goal#3:

9. Please provide any other information that you would like me to know:

Thank you for taking the time to provide this information, which we will discuss together.