PRIMACARE, LLC
MENTAL HEALTH & CONSULTATION SERVICES
PATIENT DEMOGRAPHIC FORM

Date: _____

GENERAL INFORMATION:

Name: _____ Age: _____ DOB: _____

Gender: M_____F_____ Birthplace: _____Primary Language: _____

Address: _____
Street City State Zip Code

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (____)_____

Who can we notify in case of an emergency: (Must be different than above):
Name: _____ Phone(s) _____
Address: _____Relationship: _____

Patient's Religion: _____ Culture/Ethnicity: _____

EDUCATION, EMPLOYMENT, MILITARY:
Highest Grade Completed: _____ Degree(s) Indicate Dates: _____

Certificates; Training Programs: _____

Special Education, Literacy Level/Issues: _____

Are you currently pursuing education or training: _____

Occupation (Whether or not currently employed) _____

Employer: _____Length of Employment: _____

Annual Salary: _____ Employer's Address: _____

If unemployed, how long: _____ If you have ever been fired from a job, indicate circumstances:
_____

If you have ever been fired from a job, indicate circumstances: _____

Military Service: _____ Dates: _____Type of Discharge: _____

HEALTH:
General Health (Circle One): Excellent Good Fair Poor

Serious Illness/Injury (Past or Present): _____

Major Surgeries (Including Dates): _____

Patient Name: _____

I am currently being medically treated for: _____

Doctor's Name: _____ Phone Number: _____

Medications and dosages currently prescribed: (See attached list _____yes _____no) _____

_____

_____

List any previous medications: _____

Date of Last Physical Exam: _____ Doctor's Name: _____

Family Physician: _____Phone Number: _____ Address: _____

For females: Are you currently pregnant? _____. If so, OBGYN Name: _____

Have you previously been in therapy: _____ When: _____ Why: _____

With Whom: _____ Have you been hospitalized for psychological problems: _____

Substance Abuse: _____ If yes, Facility name: _____ Dates: _____

What are your current concerns/needs:_____

Are there any family concerns: _____ If Yes, explain: _____

Who referred you here: _____

Are you a cigarette smoker: _____Yes _____No (amount) _____

Are you a coffee drinker: _____ Yes _____ No (amount) _____

How often do you drink alcohol: _____Never _____Daily _____Bi-weekly _____Weekly _____Bi-weekly _____Monthly

How often do you engage in vigorous exercise: _____

FAMILY:

Circle One: Single Married Separated Living with Partner Widowed Divorced Re-married
Living with Family _____ _____
Specify Other

Spouse or Partner's Name: _____ Age:_____ DOB: _____

Address: _____
Street City State Zip

Occupation: _____ Employer: _____

Patient Name: _____

PREVIOUS MARRIAGES (If applicable):

Dates:	Disposition:	Separated,	Divorced,	Widowed
_____	_____			
_____	_____			
_____	_____			

CHILDREN:

Name(s):	Age:	Sex:	Address (if different)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PARENTS:

Mother's Name: _____ Age: _____ (If deceased, indicate year of death) _____

Mother's Occupation (in past and current status): _____

Mother's Marital Status (circle one): Single Married Separated Living with Partner Widowed Divorced Re-married

Father's Name: _____ Age: _____ (If deceased, indicate year of death) _____

Father's Occupation (in past and current status): _____

Father's Marital Status (circle one): Single Married Separated Living with Partner Widowed Divorced Re-married

Who were you raised by: _____

SIBLINGS:

Number of Sisters: _____ Age(s) _____ (If deceased, indicate year of death) _____

Number of Brothers: _____ Age(s) _____ (If deceased, indicate year of death) _____

_____ _____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN DATE

_____ _____

SIGNATURE OF THERAPIST DATE