Patient Demographic Information Sheet

Today's Date: _____ Name: _____

Date of Birth: _____ Cell Ph: _____ Home Ph: _____
OK to leave message? Yes _____ No _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip Code: _____

Referral Source: _____

Reason(s) for Seeking Psychotherapy: _____
_____

Prior Psychological Treatment (if applicable): _____

Heath Status/Medical Conditions/Current Medications: _____
_____

Race/Ethnicity: _____ Primary Language: _____

Religious Affiliation: _____

Emergency Contact Name: _____

Phone: _____ Relation: _____

Level of Education (Please indicate years completed below):

____ High School	____ GED	____ Trade/Technical School
____ College	____ Graduate School	____ Post-Graduate Education
____ Doctorate	____ Other	

Please note, if it is important to you that your therapist know this information then please complete this section of the patient demographic form:

Sexual Identity/Orientation:
Gender Identity: _____ Do you identify as Transgender: _____

Sexual Orientation: _____

Relationship Status (Check what applies to you):
_____ Partnered _____ Married _____ Single _____ Separated _____ Divorced _____ Widowed