Center for Mind Body Health
Gwen Brehm, M.Ed., LPC, LMFT
17300 El Camino Real, Suite 107D
Houston, Texas 77058
832-741-0266

PATIENT INFORMATION FORM

Patient name: _____ Birthday: _____ Age: _____
Home address: _____ Sex: _____
_____
Social Security #: _____ Driver's license #: _____
Home phone: _____ Work phone: _____
Beeper/Cell: _____ E-mail address: _____
Best way to contact you: _____ home phone _____ cell phone
_____ e-mail _____ work phone
Employer's Name (or retired from): _____
Employer's Address: _____
Marital Status: S M W D Patient's Occupation: _____
Spouse's name: _____ Address: _____
Spouse's employer: _____ Address: _____
Person responsible for bill: _____
Emergency contact person: _____
Contact's phone: _____ Address: _____
Referring Person/Source: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Would you like us to contact your PCP? ____ Yes ____ No
Are you currently involved in a lawsuit? _____ No _____ Yes If yes, explain: _____
_____

List any inpatient or outpatient care you have received:

Hospital or Therapist	**Dates**
_____	_____
_____	_____
_____	_____
_____	_____

Do you or your relatives have a history of any of the following? (Relative):

Depression	_____ Yes	_____ No	____ Me	_____
Substance Abuse	_____ Yes	_____ No	____ Me	_____
Anxiety	_____ Yes	_____ No	____ Me	_____
Suicide	_____ Yes	_____ No	____ Me	_____
Other serious mental illness	_____ Yes	_____ No	____ Me	_____

Do you currently experience difficulty with any of the following?

_____ Anxiety/Tension	_____ Headaches	_____ Attention Span
_____ Sleep	_____ Fainting	_____ Over activity

_____ Blurred Vision	_____ Weakness	_____ Depression
_____ Dizziness	_____ Appetite	_____ Suicidal Thoughts
_____ Physical Pain	_____ Concentration	_____ Anger
_____ Nausea	_____ Guilt	_____ Fear

Are you allergic to any medication? Please list: _____

Which of the following substances do you currently use or have you used in the past? (Clients 12 years of age and older, please circle **all** that apply).

Substance	**Present use**	**Past use**	**Amount**
Alcohol	Y N	Y N	_____
Cigarettes	Y N	Y N	_____
PCP, LSD, Mescaline or other Hallucinogens	Y N	Y N	_____
Barbiturates, Sleeping Medication	Y N	Y N	_____
Cocaine/Crack	Y N	Y N	_____
Diet Pills, Speed, Uppers	Y N	Y N	_____
Heroin	Y N	Y N	_____

In the past year, I have received medical treatment for:

_____

_____

I take the following prescription drugs (include the dose and frequency):

Prescription drug	**Dose and Frequency**
_____	_____
_____	_____
_____	_____

I take the following over-the-counter drugs:

Over-the-counter drug	**Dose and Frequency**
_____	_____
_____	_____
_____	_____

Have you ever experienced sexual abuse or any negative sexual experience?

_____ Yes _____ No

Please share any information that you think would be pertinent to your need for counseling:

_____

_____

_____

_____

_____

Patient signature: _____

(If patient is a minor)
Parent or Guardian signature: _____ Date: _____