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: (____)___________

Patient's Religion: ______________________ Culture/Ethnicity: ___________________________________

Who can we notify in case of an emergency: (Must be different than above):
Name: ______________________________________ Phone(s) ___________________________________
Address: ____Relationship: _________________________

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