

NORTHLAND CLINIC

PATIENT INFORMATION SHEET

Date of Appointment _____

Patient Name _____ Age _____ Sex _____ Birth Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Social Security # _____

Are you currently employed? Yes No Part-Time Full-Time

Occupation _____ Employer _____

Employer Address _____ City _____ Zip Code _____

Education (indicate highest level achieved) _____

Marital Status: Married Single Divorced Separated Widowed

Spouse's Name _____ Birth Date _____

In Case of Emergency:

Name _____ Relationship _____ Phone _____

Children or Others in Home

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Who referred you or how did you become aware of our services? _____

Medical Insurance Information

Insurance Company Name _____ Policy # _____

Subscriber Name _____ Social Security # _____

IF PATIENT IS A CHILD OR IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT – COMPLETE

Responsible Party

Last Name _____ First Name _____ Middle Initial _____

Relationship _____

Responsible Party Complete Address

I understand that any charges not covered by my insurance will be my responsibility.

Insured or Guardian Signature _____

Patient Signature _____

Physical Status

Present state of general physical health Good Fair Poor

Please describe any physical disabilities _____

Approximate date of last complete physical exam: _____ Results _____

Name of Primary Care Physician _____

PCP's Address _____ City _____ Zip Code _____

Please list any significant past and present medical problems _____

Please list any medications you have taken for emotional/psychological/behavioral concerns and how effective they were.

| Medication | When Taken (Approx.) | Response/Reaction to Medication |
|------------|----------------------|---------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list all current medications (including both prescriptions and over-the-counter)

| Medication | When You Began this Medication | Response/Reaction to Medication |
|------------|--------------------------------|---------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list allergies _____

Have you ever been hospitalized for psychiatric problems? If so, when, where, and for how long? _____

Have you been involved in counseling or therapy for emotional problems in? If so, where, when, and for how long?

If applicable, please indicate the amount and frequency of the following:

| | Present Use | Past Use (if different) |
|------------------|-------------|-------------------------|
| Alcohol | _____ | _____ |
| Nicotine | _____ | _____ |
| Caffeine | _____ | _____ |
| Other substances | _____ | _____ |