Integrative Health Partners LLC

INFORMATION FORM

Name: _____

Date of Birth: _____ Sex: M F (circle one)

Address: _____

City, State: _____ Zip: _____

Home Phone: _____ OK to leave message? Y N (circle one)

Work Phone: _____ Cell Phone: _____

Email: _____

Have you been in therapy before? Y N (circle one)

Provider's Name: _____ Provider's phone: _____

Are you currently taking medication? Y N (circle one)

Medication/dosage: _____/_____ Prescribing physician: _____

Medication/dosage: _____/_____ Prescribing physician: _____

Medication/dosage: _____/_____ Prescribing physician: _____

Have you taken psychotropic medication in the past? Y N (circle one)

Medication/dosage: _____/_____

Emergency Contact: _____ Phone: _____

Responsible Party Information (if different from above):

Name: _____

Date of Birth: _____ Sex: M F (circle one)

Address: _____

City, State: _____ Zip: _____

Email:_____

Home Phone: _____ OK to leave message? Y N (circle one)

Work Phone: _____ Cell Phone: _____