Johannessen Psychological Services
PATIENT INFORMATION SHEET

LAST NAME________________________FIRST________________MIDDLE_____________

STREET ADDRESS ____

CITY_____________________________ STATE __________ ZIP CODE________________

PHONE: (H)____________________(W)______________________(C)___________________

ok to leave full message? _______ _______ _______

need to be discreet? _______ _______ _______

DATE OF BIRTH_______________ SOC. SEC. NO.___________________

PATIENT'S EMPLOYER____
(please list school if a child)

BUSINESS ADDRESS____
(school if it's a child)

NEXT OF KIN ____

ADDRESS____ TEL. NO___________________

IN CASE OF EMERGENCY CONTACT:

NAME____

ADDRESS____

PHONE (H)_________________ (W)__________________(C) _________

IF APPLICABLE, PLEASE PROVIDE:

LEGAL GUARDIAN'S NAME ____

ADDRESS ____

HOME PHONE _______________________ WORK PHONE ___________________________

PARTY RESPONSIBLE FOR PAYMENT:____

(PLEASE DO NOT LIST INSURANCE CO.)

ADDRESS____

HOME PHONE _______________________ WORK PHONE ____________________________

 Name________________________________

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD:

Name	Age	Relationship

I hereby authorize **Johannessen Psychological Services.** to release any **billing** information to "party responsible for payment" (Guardian/Parent's signature if a minor)

Patient's Signature_______________________________Date_________________________
(or legal representative)

I WAS REFERRED BY____

NAME OF FAMILY PHYSICIAN____

ADDRESS____ TEL NO._________________

DATE OF LAST VISIT____

Do you (patient) want this office to contact your Primary Care Physician?_________________

IF YES, PLEASE COMPLETE RELEASE OF INFORMATION
ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL ILLNESS? IF YES, PLEASE DESCRIBE:

____

____

____

HAVE YOU EVER BEEN HOSPITALIZED FOR MEDICAL OR PSYCHIATRIC REASONS? PLEASE LIST DATES AND REASONS:

____

____

____

 Name________________________________

DO YOU HAVE ANY MEDICATION OR OTHER ALLERGIES? IF SO, PLEASE LIST:

____

____

MEDICATIONS __ YES __ NO

PRESCRIBER(S) IS A __ PSYCHIATRIST __ PCP/PEDIATRICIAN __ ARNP __OTHER

CURRENT MEDICATION(S) (AND DOSAGES IFAVAILABLE):________________________

____

____

MEDICATION HISTORY:____

____

____

HAVE YOU EVER SEEN A PSYCHOTHERAPIST BEFORE? IF SO, PLEASE LIST THERAPIST, ADDRESS, AND DATE OF TREATMENT:

____

____

HAS ANYONE IN YOUR FAMILY HAD EMOTIONAL DIFFICULTIES, PSYCHIATRIC PROBLEMS, ALCOHOL OR SUBSTANCE ABUSE ISSUES? IF SO, PLEASE BRIEFLY DESCRIBE OR LIST.

____

____

PLEASE DESCRIBE ANYTHING ELSE THAT I SHOULD KNOW ABOUT YOU THAT MAY IMPACT YOUR TREATMENT?

____

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Johannessen Psychological Services, 20 Ladd Street Suite 411, Portsmouth New Hampshire 03801
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