CHAD ALLEN PSYCHOTHERAPY
Individual Psychotherapy & Couples Counseling

CHAD T. ALLEN, MA, LPC
825 NICOLLET MALL, SUITE 1240 | MINNEAPOLIS, MN 55402 | (612) 314-5520 | CHADALLENPSYCHOTHERAPY.COM

PATIENT INFORMATION FORM

The information requested below is to help me work with you. Please fill out this form as completely as possible. The information you provide here will be treated as confidential unless otherwise directed by law.

Patient's Name: _____ DOB: ___/___/_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ ☐Home ☐Work ☐Mobile

May I leave a message? ☐Yes ☐No Email: _____

I identify my sex as: ☐Female ☐Male ☐Intersex ☐MtF Female ☐FtM Male

I identify my gender as: ☐Man ☐Woman ☐Trans* ☐Other: _____

Relational Status: ☐Partnered ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Number of household members: _____ Number of adults in household: _____

Children and ages: _____

Do you consider yourself to be spiritual or religious? ☐Yes ☐No

If yes, please describe: _____

Ethnicity/national origin (or similar way you identify yourself and consider important):

_____

Level of Education: ☐High School ☐High School Equivalency ☐Some College
☐College ☐Graduate School ☐Post-Graduate ☐Trade/Technical School ☐Other

Parent/Guardian Information (if patient is a minor)

Parent 1

Parent's Name: _____ Rel. to Patient: _____

Preferred Phone: _____ ☐Home ☐Work ☐Mobile

May I leave a message? ☐Yes ☐No Email: _____

Parent 2

Parent's Name: _____ Rel. to Patient: _____

Preferred Phone: _____ ☐Home ☐Work ☐Mobile

May I leave a message? ☐Yes ☐No Email: _____

Marital Status: ☐Partnered ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Are parents living together? ☐Yes ☐No If No, please explain custody arrangement:

_____

Referral Information

Referral Source: _____

If referred by an individual, may I ask who referred you? _____

May I contact this person to thank her or him for the referral? ☐Yes ☐No

Employment Information

Employment: ☐Full-time ☐Part-time ☐Unemployed ☐Retired ☐Disabled ☐Student

Current Employer: _____ Occupation: _____

Title: _____ Years in position: _____

Gross Annual Income (only if requesting adjusted fee): _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Medical Care

From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

Date of last physical exam: _____

Treatment

Have you ever received psychological, psychiatric, or psychotherapy services before?
☐No ☐Yes If yes, please indicate:

When?	From whom?	For what?	With what result?

Have you ever taken medications for psychiatric or emotional problems? ☐No ☐Yes
If yes, please indicate:

When?	Which medications?	For what?	With what result?

Have you ever received drug or alcohol treatment? □No □Yes If yes, please indicate:

When?	From Whom?	For what?	With what result?

General Health and Mental Health

1. How would you rate your current physical health?
□Poor □Unsatisfactory □Satisfactory □Good □Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your sleeping habits?
□Poor □Unsatisfactory □Satisfactory □Good □Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Do you smoke or chew tobacco? □No □Yes If yes, how much per week? _____

6. Do you drink alcohol more than once a week? □No □Yes

If yes, how much do you consume each week on average? _____

7. How often do you engage in recreational drug use?
□Daily □Weekly □Monthly □Infrequently □Never

8. Are you currently experiencing overwhelming sadness, grief or depression? □No □Yes

If yes, for approximately how long? _____

9. Are you currently experiencing anxiety, panic attacks or have any phobias? □No □Yes

If yes, for approximately how long? _____

10. Have you had suicidal thoughts recently?
□Frequently □Sometimes □Rarely □Never

11. Have you had suicidal thoughts in the past?
□Frequently □Sometimes □Rarely □Never

12. Have you ever experienced any of the following?

Extreme depressed mood:	□No □Yes	Phobias:	□No □Yes
Mood Swings:	□No □Yes	Extreme Anxiety:	□No □Yes
Hallucinations:	□No □Yes	Panic Attacks:	□No □Yes
Body Image Problems:	□No □Yes	Eating Disorder:	□No □Yes
Obsessions/Compulsions:	□No □Yes	Homicidal thoughts:	□No □Yes
Alcohol/Substance Abuse:	□No □Yes	Suicidal thoughts:	□No □Yes

13. Are you currently in a romantic relationship? □No □Yes If yes, how long?_____

On a scale of 1—10, how would you rate the quality of your relationship? _____

14. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

Family Mental Health History

Has anyone in your family experienced difficulties with the following?
Check all that apply and please indicate your relationship to that family member.

☐Depression _____ ☐Anxiety Disorders_____
☐Schizophrenia _____ ☐Eating Disorders _____
☐Alcohol/Substance Abuse _____ ☐Bipolar Disorder_____
☐Trauma History _____ ☐Suicide Attempts_____

Please briefly describe your current situation and what led you to seek counseling/therapy:

Signature of Patient or Parent/Guardian Date

Printed Name of Patient or Parent/Guardian