PATIENT INFORMATION

Name: _____

Address: (ok to send mail to this address? Y/N)_____

_____

Telephone Numbers: (days) _____ ok to leave message? Y N
(evenings) _____ ok to leave message? Y N
(cell) _____ ok to leave message? Y N

Person to contact in case of emergency: _____

_____

What medications are you on? _____

General Physician: _____ Phone: _____

Your age: _____ Date of Birth: _____ Occupation: _____

Marital Status: (Circle one) Single Engaged Married Separated Divorced
Widowed Common-law

Any children? If so, how many, how old? _____

Whom do you live with? _____

Are you eligible for Medicare? Y N

How did you hear about me (check any that apply)?

- ☐ Referred by another clinician:_____
- ☐ Academy of Cognitive Therapy (ACT)
- ☐ OC Foundation
- ☐ Association of Behavior and Cognitive Therapy (ABCT)
- ☐ Web search (what search words):_____
- ☐ Other:_____