PATHWAY CENTER
for Psychotherapy

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INDIVIDUAL INFORMATION FORM

Patient's
Full Name: ____ Today's Date: ____/____/____

Address: ______________________________City/State: _______________ Zip: _________

Social Security Number: ___________________ For Insurance Purposes: Married Single Other

Age: _______ Birth Date: _______________ Email: ________________________________

Telephone: Home: ________________ Work: ________________ Cell: ________________

Emergency contact:
Name _________________________ Relationship: ___________ Telephone: ____________

Employer and Occupation: ____

Education: ____

Spirituality/Religious Preference: ____

How important are spiritual/religious matters to you?

☐ Not Important ☐ A Little Important ☐ Very Important

Who is your regular physician? ____

☐ I give my therapist permission to inform my physician that I am receiving treatment from my therapist. *(If checked, please provide contact information for your physician)*

Physician's
Address: ______________________________City/State_________________ Zip: ___________

Physician's Telephone: ___________________
Describe any major health problems you have had: _____________________________________

____

List medications you use regularly: ____

Do you smoke? ____ Now _____ In past
Do you use caffeine? ____ Now _____ In past
Do you drink Alcohol? ____ Now _____ In past

If now, about how many drinks per day? ___________ Per week? ________
Have you ever tried to stop drinking? _______________
Has anyone ever told you they had a problem with your drinking? _____________
Have you ever been treated for alcohol use or abuse? _______________________
If yes, where and when? ____

Do you use any other substances? _____Now _____ In past

If now, which substances and how often? ______________________________________
Have you ever had treatment for substance abuse? _____________________________________
If yes, where and when? ____

Describe your reason for seeking help: ____

____

____

What efforts have you made to handle the problem? ____________________________________

____

____

Do you see any other person as being involved in your problem? _________________________

If so, who? ______________________________ Relationship _____________________________

How? ____

To whom have you turned to for help or support? _______________________________________

How were they of assistance? ____

Who suggested you contact us? ____

Have you ever received psychiatric or psychological help or counseling of any kind before? ____

____

When and where? ____

Please circle any of the following problems that pertain to you:

Nervousness
Friends
Self-Control
Sexual Problems
Stomach trouble
Relaxation
Concentration
Decisions
Education
Depression

Suicide
Appetite
Anger
Unhappiness
Headaches
Inferiority
Loneliness
Unusual visuals
Alcohol Use

Children
Drug Use
Finances
Career Choices
Bowel Troubles
Energy
Unusual sounds
Health problems
Temper
Separation

Nightmares
Being a parent
Stress
Legal Matters
Insomnia
My thoughts
Tiredness
Shyness
Divorce

Marriage
Fears
Sleep
Work
Memory
Ambition

Please list any other problems not on this list: ____

____

Please list members of your family and others in your home:

Name	Age	Relationship	Occupation

____

____

____

INSURANCE COVERAGE: ____

Policy Number: ________________________________ I.D. No. _______________________

Are you currently involved in any legal matters? ☐ Yes ☐ No

If yes, please describe: ____

____

AGREEMENT FOR THERAPY

1. Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations should be made at least 24 hours in advance, or you will be billed for the session.

2. Therapy sessions will be 50 minutes in length unless otherwise agreed upon by you and your therapist.

3. Payment for services are due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.

4. If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency.

5. By signing this form, I acknowledge that I have read, understand, and agree to the above, including a treatment plan of psychotherapy to address the presenting problem.

Signature　　　　　　　　　　　　　　　Date