Empower Therapy for Women, LLC

Patient Information Form

Full Name _____

Preferred Name/Nickname _____ Date of Birth ___/ ____/ ____

Home Address _____

City/State _____ Zip Code _____

Email Address _____

Best Phone Number _____ Secondary Phone Number: _____

May we leave voicemail messages on your phone? ____ Yes ____ No

May we send texts to your phone regarding upcoming appointments? ____ Yes ____ No

May we send you emails regarding upcoming appointments? ____ Yes ____ No

Marital Status (circle) Single / Married / Partnered / Divorced / Separated / Widowed

Do you have children? Yes / No If yes, names and ages: _____

_____

Are You Currently Pregnant? Yes / No Number of Total Pregnancies ____

Physician: _____

Women's Health Doctor (if applicable): _____

Psychiatrist (if applicable): _____

Significant Health Problems: _____

_____

Current Medications: _____

Names of any previous psychomedications: _____

Other Therapists Seen (When & How Long) _____

Employment Status (circle all that apply): Employed for Financial Gain / Primary Childcare Provider / Student / Volunteer / Retired / Disability Status

Name of Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

How did you learn of us?: ____ Google Search ____Psychologytoday

____ Referred by: _____

____ Other