

Who is your primary physician?

Name and Address: _____

Are you being treated for any medical condition and/or taking any medication? (please describe)

What has led you to seek treatment at this time?

How long have you been concerned about what has brought you to treatment? _____

Have you or a family member ever been treated at West Bergen? _____

By Whom and When? _____

Have you previously consulted with a Mental Health Professional? ____Y ____N

If yes, Who? _____ Date(s): _____ Where: _____

Have you ever been hospitalized for mental health problems? ____Y ____N

If yes, Date(s): _____ Where: _____

There may be times when your therapist would consider it important to speak with a family member or friend as part of making a thorough assessment or otherwise supporting your treatment. This communication would take place only with persons whom you designate and with your knowledge and consent. Please check one of the following:

- Yes, I would give my permission for such communication.
(Please sign consent forms)
- No, I would prefer not to have any communication concerning my treatment shared with family and/or friends.

In the event of an emergency, whom may we contact?

Name	Address	Phone
_____	_____	_____
_____	_____	_____

Name	Address	Phone
_____	_____	_____
_____	_____	_____

We would appreciate it if you would provide us with any other information that you believe is important to a fuller understanding of you and your circumstances.
