2019 Compass Intake Form

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____

Address:_____

Home Phone: _____Cell/Work: _____

Email: _____

Date of
Birth:_____Gender:_____

Primary Physician: _____ Psychiatrist (if any)_____

Emergency Contact Person: _____ Emergency Contact Phone: _____

Marital Status:_____ How did you hear about us? _____

What are some of the difficulties that brought you here?

What strategies have you tried that have been successful for you?

What have you tried that has NOT been successful?

MEDICAL INFORMATION

Are you on medication? Yes No If YES, what type(s) and dosage?

Do you have allergies? Yes No If YES, what are you allergic to?

Please list all surgeries (and dates)

Have you ever been hospitalized for an extended period of time? Yes No

Cause of hospitalization:

Compass Therapist_____Date:_____