The Center for Sexual Health and Family Counseling of Orlando, LLC
Individual, Couples and Family Therapy

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Patient Information Form

Today's date: _____

Therapy I am seeking: ☐ Individual ☐ Couple ☐ Family ☐ Group Therapy

Patient Information:

Full Name: _____		Preferred Name: _____
Date of Birth: _____/_____/_____	Age: _____	Social Security #: _____
Address: _____		
City: _____	State: _____	Zip code: _____
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Decline to answer		
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐ Other		
Birthplace: _____		
Primary cultural background: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other:_____		

Employer and Status:

Occupation: _____	How long? _____
Employment Status: ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Retired ☐ Student ☐ Unemployed	
Employer/School: _____	Employer Phone # (_____) _____
Employer Address: _____	

Phone Numbers:

Home Phone # (_____) _____	Is it ok to leave a message? ☐ Yes or ☐ No
Alternative Phone # (_____) _____	Is it ok to leave a message? ☐ Yes or ☐ No
Email Address: _____	

Emergency Contact Info:

Name: _____	Relationship: _____
Home Phone # (_____) _____	Alternative Phone # (_____) _____

Sexual History:

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other: _____	
I am: ☐ currently sexually **active** ☐ currently sexually **inactiv**e	I am: ☐ currently sexually **dissatisfied** ☐ currently sexually **satisfied**
Age of first sexual experience: _____	Age first pregnancy/fatherhood: _____

Abuse History:

Has there been a history of abuse (were you abused) in your life? ☐ Yes or ☐ No
If yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal ☐ Neglect ☐ Domestic Violence

Medical History:

Describe current physical health? ☐ Good ☐ Fair ☐ Poor
Current medical conditions or problems: _____ _____ _____ _____
List any surgeries or illnesses you have had the past five years: _____ _____ _____ _____

Medical Care Providers:

Physician: _____	Phone: _____ Fax:_____
Physician Address: _____	
Psychiatrist: _____	Phone: _____ Fax:_____
Psychiatrist Address: _____	
*It is our practice to coordinate care with the client's medical doctor(s) when this would be helpful. If you agree that we may contact your physician and/or psychiatrist, please check here: ☐ Yes or ☐ No *(Please sign a release of information with your therapist for this purpose.)*	

Medications:

List any medications, including the amount that you currently take or have taken in the past 3 months:

Medication	**Dosage**	**Purpose**	**Start Date**

This is a strictly confidential medical record. Disclosure or transfer is expressly prohibited by law, unless consent for said disclosure is obtained with your expressed written permission and/or other exemptions apply.