Calla Belkin, Psy.D.
PO Box 5494, Richmond, CA 94805
(510) 863-1490
Lic. #: PSY 21822

NEW PATIENT INFORMATION FORM

Name _____ Date Completed: ____/____/____

Reason for Seeking Therapy: _____

Method of Referral: _____

Home Address (city, state, zip code): _____

_____

Phone numbers (check preferred number):

o Home (_____)_____ Confidential message OK? o Yes o No

o Work (_____)_____ Confidential message OK? o Yes o No

o Cell (_____)_____ Confidential message OK? o Yes o No

Email Address(es): _____

Emergency Contact (name, phone): _____

Date of Birth ____/____/____ Age _____

Occupation: _____ Highest Grade/Degree: _____

Relationship Status: _____ Partner's Name: _____

Partner's Date of Birth: ____/____/____ Partner's Occupation: _____

Dates of Marriage(s): _____

Others in Home (name, age, relationship): _____

_____

Children Outside Home (name, age): _____

Siblings (name, age, gender): _____

Parents/Step-Parents (age or year of death): _____

Medical Doctor (name /phone): _____

Date of Last Exam: ____/____/____ Current Medication: _____

Major Medical History (injuries, illnesses, hospitalizations): _____

_____

_____

Previous providers of mental health care (name, dates, focus of treatment):

_____

_____

_____

Psychiatric Hospitalizations (dates, reasons): _____

_____

History of self-harm: o Yes o No History of Violent Behavior? o Yes o No

Current Drug/Alcohol Use (substance, amount, frequency): _____

_____

Prior Addictions (dates, method of addiction, treatment): _____

_____

Family History of Metal Illness, Suicide, Addiction, Violence: _____

_____

_____

Current/Pending Civil or Criminal Litigation, Lawsuit, or Divorce or Custody Disputes:

_____

_____

Use the space below to provide additional information: