Women's Mental Health Associates and Health Psychology Solutions

Patient Information

Date:

Patient Complete Name (include middle initial if you have one):

Date of Birth:

Home address with zip code:

Cell phone:

Is it acceptable to leave a message on your cell phone? No or yes

Email:

Is it acceptable to email you with practice related forms? No or Yes

Race/Ethnicity:

Relationship status: Single, Partnered, Married, Separated, Divorced, Widowed, Other

Preferred pronouns:

Emergency contact name:

Relationship to you:

Emergency contact cell phone:

Health Insurance Information:

Primary Health Insurance Policy:

Name of health insurance company:

Health Insurance Policy ID:

Health Insurance Group Number:

Secondary Health Insurance Policy:

Name of health insurance company:

Health Insurance Policy ID:

Health Insurance Group Number:

Health Care Provider Information

Referring health care provider: Complete name and phone number.

Primary Health Care Provider: Complete name and phone number.

Other specialty medical providers involved in your care: Complete name (s) and phone number.

Physical Conditions

List physical concerns and diagnoses here and indicate if they are in the past or current. For example - Have you had prior or are you undergoing current treatment for cancer, cardiac conditions, GI conditions, Autoimmune conditions, COVID, HIV/AIDS, solid organ transplants, persistent pain or other chronic or life-threatening physical conditions? Please provide details here.

Physical Condition or Symptom	Year of Diagnosis	Past/Resolved	Current/Ongoing Symptoms or Care	Treating Provider(s)	Provider location

Date of Last Physical:

Medication Information

Please list current prescription medications, over-the-counter drugs, vitamins, and herbal supplements below.

Name of medication, vitamin, etc.	Reason for medication	Dose	Prescriber	Comments

Surgery History:

Type of Surgery	Year of Surgery	Surgeon and Location
