Leslie A. Campbell, LCSW
Five Tribes Therapy
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PATIENT INFORMATION

Date: ____

DOB: ____

Age: ____

SS# (optional): ____

DL # (optional): ____

Name: ____

Address *(street, city, state, zip code)*: ________________________________
____

Phone *(home/work/cell)*: ________________________________

Email Address: ________________________________

Venmo *(if applicable)*: ________________________________

Married ( ) Single ( ) Divorced ( ) Separated ( )

Name of partner/spouse: ________________________________

Emergency Contact *(relationship/phone)*: ________________________________

FAMILY HISTORY

With whom do you live?: ________________________________

Children's names and ages: ________________________________

MEDICAL HISTORY

Personal Physician and Contact Information *(if applicable)*: ________________________

Psychiatrist and Contact Information *(if applicable)*: ________________________

Other Medical Providers and Contact Information. *Please complete this portion of the information form if applicable*

____
____

Medication *(dosage & frequency)*: ________________________________

Medication *(dosage & frequency)*: ________________________________

Medication *(dosage & frequency)*: ________________________________

Medication *(dosage & frequency)*: ________________________________

Date and Results of Last Medical Exam: ________________________________
____

Current Nonprescription Drug Use/Frequency: ____
Did your parents use drugs/alcohol? ____
Have you had mental health treatment before? *(dates/with whom/where/why)*:
____
____

What brings you to therapy now? ____
What else would you like me to know? ____
What would you like to achieve in therapy? ____
Who referred you to me? ____

RESPONSIBLE PARTY

Name: ____
Address *(street, city, state, zip code)*: ____
____

Phone *(home/work/cell)*: ____
Email Address *(if applicable)*: ____
Venmo *(if applicable)*: ____

EMPLOYER

Name: ____
Address *(street, city, state, zip code)*: ____
Phone *(home/work/cell)*: ____
Email Address *(if applicable)*: ____

CONFIDENTIALITY

Communication between patient and therapist is privileged except child, elder or dependent abuse and/or a threat to the life of another person. If you have managed health care, their utilization review panel will be involved. Confidentiality law binds them.

RELEASE OF INFORMATION

This form must be signed and approved by you if you wish that records or information be released to any others except to your insurance/managed care provider.

I authorize this office to release any information necessary to expedite coordination of care. A copy of this signature is valid as the original.

I consent to assessment and treatment under the care of Leslie A. Campbell, LCSW, Five Tribes Therapy. I have read and understand the above stipulations.

Signed & Dated: ____