Leslie A. Campbell, LCSW
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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)*: ______________________________
Zelle *(preferred, 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:

________________________________________________________