HAWAII CENTER
for PSYCHOLOGY

FINDING YOUR BALANCE

Name____ Date of Birth_______________

Parents name (if patient is a minor)____

Mailing Address: ____
STREET CITY ZIP CODE

Contact number:

Primary #:_____________________________Secondary #:___________________________

Patient's marital status: ☐Single ☐Married ☐Separated ☐ Divorced ☐ Widowed

Emergency Contact:

Name: ____Relationship ______________________

Primary #:_____________________________Secondary #:___________________________

Briefly describe reason for seeking therapy at this time___________________________________

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How did you learn about our practice?____

Name of Patients Primary Care Physician(s)_______________________________________

Has patient ever seen a psychotherapist before? ☐Yes ☐ No
Did you consider the therapy successful? ☐Yes ☐ No ☐Maybe ______________________

If so, please list the name of therapist and the approximate dates seen

____

Has patient ever been hospitalized for a psychiatric illness? ___________________________

If so when and where? ____

Has anyone in patients family ever been diagnosed with a psychiatric disorder? ☐Yes ☐ No

Please list any and all medications (prescription and over the counter) patient is currently taking

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Please list any and all supplements (vitamins, herbs, naturopathic remedies, etc) patient is currently taking

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