Melvin L. Cauthen, LICSW, LCSW-C

Motivating Life Changes

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202-555-5555

**NEW PATIENT FORM**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT HISTORY**

Have you seen a therapist/psychiatrist previously? \_\_\_\_\_YES \_\_\_\_\_\_NO

Name of providers and dates of treatment:

Current medications and dosages (s):

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Check the concerns that apply to you:

\_\_\_ Depression

\_\_\_ Anxiety

\_\_\_ Weight loss issues

\_\_\_ Relationship concerns

\_\_\_ Family concerns

\_\_\_ Gay and Lesbian issues

\_\_\_ Sexual Identity issues

\_\_\_ Other (add your own concerns here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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