GREENWICH PSYCHOTHERAPY & ASSOCIATES
30 WASHINGTON AVE,
GREENWICH, CT 06830
T: 203-862-8940
F: 203-286-1653

PATIENT INFORMATION

Name: _____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

SSN: _____-_____-_____

Name of Parents (if under 18 years): _____

Marital Status: _____

Child Custody Status (if applicable): _____

Address: _____

_____

Please list all siblings/children/other relatives at home: _____

_____

Contact Information

Home Phone: _____ Is it okay to leave a message here? Y / N

Office Phone: _____ Is it okay to leave a message here? Y / N

Cell Phone: _____ Is it okay to text this cell phone? Y / N

E-mail: _____

*** Please note: texting and email correspondence are not considered to be confidential forms of communication. It is important to be aware of this when using these modes for communication ***

How were you referred to Greenwich Psychotherapy and Associates? _____

_____

Reason for referral: _____

Do you have a preferred GPA therapist? If so, whom? _____

Have you previously been in therapy or received other types of mental health services: Y/ N

If yes: Type of service: _____

Name of Provider: _____

Previous Diagnosis (if any): _____

Please complete the table below with any medications you have taken on a regular basis including any that you are currently taking

Name of Med	Dates Taken	Prescribing Dr.	Response to Meds

What are your goals for therapy? What do you hope to accomplish in session?

Is there any other information that you feel would be important or helpful for us to know?