# The Center *for* Healthy Minds

**Date:** ______________________________________

**Full Name:** ______________________________ **Preferred Name** __________

**Date of Birth:** __________________ **Age** ___________

**Address:** ____________________________________________ **Apt. #:** _______

**City:** __________________ **State:** ____________ **Zip Code:** _________

**Home Telephone:** ____________________ **Cell Phone:** ____________________

**Work Telephone:** ____________________ **E-mail address:** __________________

**Social Security #:** _______________ **Employer:** ___________________________

**Referred by:** _____________________________________________________

**Do you have any allergies to medications? (If yes, please describe)**

_______________________________________________________________

**Do you have any medical problems? (If yes, please describe)**

_______________________________________________________________

_______________________________________________________________

**Are you currently taking any medication regularly? (If yes, please list)**

_______________________________________________________________

_______________________________________________________________

**Are you regularly cared for by a physician?** ___________________________

**Physician Name:** _____________________________________________________

**Telephone Number:** __________________ **FAX Number:** __________________

**What Pharmacy do you use?** ________________________________________

**Pharmacy Telephone #:** _________________ **Pharmacy FAX #:** _______________

**Pharmacy Address:** ___________________________________________________

**Whom should I contact in an emergency?**

**Name:** _____________________________ **Relationship:** __________________

**Address:** ___________________________ **Telephone:** ____________________

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