Welsh Counseling
& Coaching Inc.

P.O. Box 8151

Evanston, Illinois 60204

Adult Patient Information Form

Today's Date: _____ **Date of Birth:** _____ **Age:** _____

Full Name: _____ **What would you prefer I call you?** _____

Gender: _____ **Sexual Orientation:** _____ **Race/Ethnicity:** _____

Partner/Relationship Status: _____ **Partner Name:** _____

Current Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Preferred Phone Number (home/work/cell): (_____) _____

Secondary Phone Number (home/work/cell): (_____) _____

Referring Provider: _____

Current Psychiatric Medications: _____

Previous Mental Health Services: _____

Presenting Problems: _____

Emergency Contact Information

Name: _____ **Relationship to Patient:** _____ **Phone:** (____) _____