5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-4000
f. (443) 546-4005
www.collaborativecounselingcenter.com

Clinical Information Form

Patient Name: ____________________________________ Preferred Gender and Pronouns: __________

Why are you seeking help at this time? Please include mental health concerns.

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____
____
____

What are your goals for the current treatment/evaluation?

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____
____

Mental Health History

Past mental health treatment:
For example, outpatient therapy, medication management, residential or inpatient treatment, TMS, etc.

____
____
____

Past mental health diagnoses: ____

Diagnoses and approximate date/age diagnosed: ____

Have you ever been prescribed medication for psychiatric treatment? (circle one) Yes No

Are you currently being prescribed medication for psychiatric treatment? (circle one) Yes No

If YES to either above, please fill out below to the best of your knowledge:
Include medication name, dose, start/end dates, side effects (if applicable) and reasons for stopping (if applicable)

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____
____

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Medical Information

Primary Care Physician Name: ____

Office Name: ____________________________ Office Phone Number: _______________

Other specialists providing you care: ____

Office name and phone number: ____

Please list any current medications and previous medications (include prescription and over-the-counter), excluding psychiatric medications:
Please include medication name, dose, length of treatment, start/end date, side effects (if applicable) and reason for stopping the medication.

____

____

Please list and describe any current or past medical diagnoses or conditions:

____

____

Do you have any allergies? (circle one) Yes No

If YES, please elaborate (what you are allergic to and reactions):

____

____

Social History

Marital Status: ______________________________

Please note any current stressors in your life:

____

____

____

Education/Employment History

Highest level of education completed: ____

Are you currently employed? (circle one) Yes No