Integrated Behavioral Services, INC
9403 Kenwood Rd, suite A120 Cincinnati, Ohio 45242

Patient Information

Today's Date _____/_____/_____
Name (Last, First, Middle)_____
Home Address _____
_____
Home PH# ( ) _____/_____ OK to call? Yes_____ No _____
Work/Cell PH# ( ) _____/_____ OK to call? Yes_____ No _____
Birthdate: _____/_____/_____ Age:_____ SSN#:_____/_____/_____
Email: _____

Marital Status:_____ How Long?:_____ Other Marriage(s): _____
(Dates)_____
Occupation: _____
Work Address: _____
Education: _____

Members of immediate Family	Relationship	Birth date	Age
1.			
2.			
3.			
4.			

Family history of Mental Illness? Yes ___ No___
Please describe _____
_____
Person responsible for the bill: _____
Primary Care Physician: _____
Primary Care Physician Address: _____
Primary Care Physician PH #: ( ) _____/_____
Previous psychiatrist: _____ Previous/Current Therapist:_____
Current Medications: _____
_____
Allergic to: _____
Current treated illness: _____
Have you ever had/ or been involved with any alternative medicine treatments or providers?
Yes____ No____ If yes what provider and what for? _____
Emergency Contact: _____ Relationship:_____
Emergency Contact PH#: ( ) _____/_____
Do you have a living will? Yes_____ No_____

ACKNOWLEDGEMENT: I UNDERSTAND AND AGREE TO PAY ANY CANCELLATION FEES WHICH WILL BE CHARGED FOR APPOINTMENTS THAT I MISS OR CANCEL WITH LESS THAN 24 HOUR NOTICE.

SIGNED:_____ DATE:_____/_____/_____
RESPONSIBLE PARTY