Erica B. Saypol, Ph.D., LLC
76 Elm Street, Suite 203
New Canaan, CT 06840
917.691.7985

Patient

Name _____ Date _____

Address _____

City, State, Zip _____

May we write you at your home address? Yes ___ No ___

Birth-date _____

Occupation _____ Employer or School_____

Sex _____ Ethnicity _____

Marital Status _____ Religion _____

Home Phone (_____)_____ May we leave detailed messages? Yes___ No___

Cell Phone (_____)_____ May we leave detailed messages? Yes___ No__

Work Phone_(_____)_____ May we leave detailed messages? Yes___ No__

Which is your preferred contact number? Home___ Cell___ Work___

Fax Number _(_____)_____ May we send you faxes? Yes___ No__

Email Address: _____May we email you? Yes___ No__

Referred by

Name _____ Phone (_____)_____

Address _____

City, State, Zip _____

Emergency Contact

Name_____

Relationship to Patient_____

Address _____

City, State, Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____

Additional Information

Primary Care Doctor_____ Phone_____

Psychiatrist_____ Phone_____

Current
Medications/Dosages_____
_____

Past/Present Medical
Conditions_____
_____

Have you been in psychotherapy before? Yes___ No___ If yes, then:

Please list previous therapist(s) name(s), date ranges of services, reasons for treatment, and reason for termination:

Name	Date Range	Reason for Treatment	Reason for Termination

Reason for today's
visit?_____
_____
_____

Highest Level of Education Completed _____

Please list the age of each parent (or age when deceased)
Mother___ Father___

Do you have siblings? Yes___ No___ If so, please list sex and age of each
_____

Have any of the following relatives had psychological difficulties (whether or not they received treatment)?

Relative	Yes / No	Type of Problem (e.g., anxiety, depression, bipolar disorder, schizophrenia, etc.)
Mother		
Father		
Siblings		
Aunts/Uncles		
Cousins		
Grandparents		