



*The Self-Care Path, LLC*  
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## PATIENT INFORMATION

Full Name: \_\_\_\_\_

Significant Others' Names (Couples/Family Counseling): \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Email (to receive automatic appointment reminders): \_\_\_\_\_

## PRESENTING ISSUE

*Please write a brief phrase or sentence about why you are seeking counseling*

\_\_\_\_\_

## MEDICAL HISTORY INFORMATION

Physician: \_\_\_\_\_

Medical Diagnoses: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

## PSYCHIATRIC HISTORY INFORMATION

Prior Psychological Support Services:    Yes    No

Provider(s): \_\_\_\_\_  
(optional)

Known Diagnoses: \_\_\_\_\_

Psychiatric Medications: \_\_\_\_\_

**RELEASE OF INFORMATION** *please check here if you have filled out a ROI Form*

Please fill out our *Release of Information Form* if you need us to release information about your counseling with us. Leave it blank/no need to print if it does not apply to you.

**PLEASE LIST OCCUPATION IF YOU ARE A FIRST RESPONDER:** \_\_\_\_\_