Reset Form

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PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ ☐ Male ☐ Female ☐ _____

Date of Birth: _____ Age: _____ Relationship Status: _____ - _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (_____) _____

Employer and Position: _____ Work Phone: (_____) _____

E-mail address for communication from our office: _____ SS# _____ - _____ - _____

Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____

**How were you referred to Dr. Gustke: _____

Therapist: _____ PCP: _____

****Please Fill Out Attached Release of Information Form To Allow Communication Between Your Providers****

Person Responsible for Payment: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Responsible Party: _____ SS# _____ - _____ - _____ Date of Birth _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Email Address: _____

Employer and Position: _____ Work Phone: (_____) _____

Parent Information

Mother's Name: _____

Occupation: _____ Cell Phone: (_____) _____

Father's Name: _____

Occupation: _____ Cell Phone: (_____) _____

Briefly explain the difficulties that caused you to seek evaluation at this time: _____

_____

_____

How long has this problem been of concern to you? _____

When was this difficulty first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Please describe any major event that you feel might be related to the problem: _____

_____