MIRACLE Counseling

PATIENT CHART

Initial verification completed by Office Personnel _____ Date _____

DEMOGRAPHICS

Name:		Sex – F M Other
DOB:	Languages:	
Home #	Cell #	Email:
Address:		

EMPLOYMENT

Full-Time	Part-Time	Student	Unemployed	Military	Disabled	Retired

Employer Name:	Address:
Position:	Phone Number:

EDUCATION

Full-Time	Part-Time	Not Applicable	Institution:

EMERGENCY CONTACT #1

Name:		Sex – F M Other
Languages:	Relation to Patient:	
Home #:	Cell #:	
Address:		

EMERGENCY CONTACT #2

Name:		Sex – F M Other
Languages:	Relation to Patient:	
Home #:	Cell #:	
Address:		

MIRACLE Counseling

ACTIVE MEDICATIONS (Use additional paper if needed)		
Name of Medication	Quantity	Frequency
DISCONTINUED MEDICATIONS (Use additional paper if needed)		
Name of Medication	Quantity	Frequency
ALLERGIES (Use additional paper if needed)		
Name of Medication	Quantity	Frequency

Parent's Names – Mother: **Father:**

Other important information:

This form was completed to the best of my knowledge and ability. However, my responsibility will remain to update Miracle Counseling and Life Coaching LLC on any future changes.

Patient's Name Signature Date

Relationship to Patient Signature Date