DR. JAAN REITAV
PSYCHOLOGIST

NAME:_____ Date of Birth: _____

Home Address: _____

_____

_____

Telephone: _____

Occupation: _____

Work Address: _____

_____

_____

Telephone: _____

Referred here by: _____

FAMILY DOCTOR: _____ Tel: _____

When was your last visit? _____

Do you have any medical problems now? _____

If yes, describe: _____

_____

Are you taking any medications now? NO ____ YES ____

Medication(s): _____

NEXT OF KIN: _____ Relationship to you: _____

Address: _____

Telephone: _____

PRESENT MARITAL STATUS: _____

Do you have EXTENDED HEALTH INSURANCE? _____

Name of Company: _____

Please list all the children in your family of origin in order of age (including yourself):

Name	Age	Health

Educational History: (List all post-secondary education and/or training)

Previous mental health contacts:

Who referred you?

Presenting Problem: (Reason you are here)

Identifying Characteristics of problem: (Symptoms; Nature of difficulty; Why it's a problem)

Therapeutic Goals: (What you would like to accomplish)