PRIOR MENTAL HEALTH INFORMATION

Patient Name: ____

☐ No prior mental health services

Provider/Facility Name: ____
Address: ____
City/State/Zip: ____
Phone: ____________________________ Fax: _______________________

Permission to obtain records: ☐ Yes ☐ No

Provider/Facility Name: ____
Address: ____
City/State/Zip: ____
Phone: ____________________________ Fax: _______________________

Permission to obtain records: ☐ Yes ☐ No

Provider/Facility Name: ____
Address: ____
City/State/Zip: ____
Phone: ____________________________ Fax: _______________________

Permission to obtain records: ☐ Yes ☐ No

Provider/Facility Name: ____
Address: ____
City/State/Zip: ____
Phone: ____________________________ Fax: _______________________

Permission to obtain records: ☐ Yes ☐ No

_______________________ _________________________________
Date Signature