Client Information

Name: ____Birth Date: ------/------/-------

Address: ____

Home Phone: ________________________ May I leave a message? □Yes □No

Cell/ Phone:_________________________ May I leave a VM? □Yes □No

Email: _______________________________ May I email you? □Yes □No

*Note: Email correspondence and texts are not guaranteed as a confidential method of communication. If you choose to use it please limit to details like scheduling and know that by checking the boxes you are allowing its use. *Please initial here:______.

Insurance Provider: ____

Member ID:
____

Primary insurance holder's name and date of birth:
____

Do you have secondary insurance, if so what provider:
____

Emergency Contact Information and Relationship:

____

Referred by?:____

Have you previously received any type of therapy or mental health services (psychotherapy, psychiatric help, counseling, self help, etc.)?

□ No □ Yes, previous therapist/practitioner and time table:
____

Describe that process and if it was helpful:
____

____

____

Are you currently employed or in school? □ No □ Yes, What is your situation?

____

Rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good

Describe health:
____

____

Describe current sleeping habits (please circle) Poor Unsatisfactory Satisfactory Good

Describe any sleep problems you are experiencing:

____

____

Describe any difficulties with your appetite or eating habits:

____

____

Are you currently experiencing anxiety, panic attack, obsessions, compulsions, fears, phobias?

□ No □ Yes If yes, when did you begin experiencing this?_________________________

Describe:____

____

____

____

Are you currently experiencing sadness, grief, depression? □ No □ Yes If yes, how long?

Describe____

____

____

____

Have you had or are you currently having thoughts of harming yourself? □ No □ Yes If yes,
Describe:____

____

____

Have you had any suicide attempts? □ No □ Yes: If yes, describe circumstances/dates:

____

____

____

Describe any trauma history:

____

____

____

Are you currently experiencing any acute or chronic pain? □ No □ Yes; If yes, describe:

____

____

Are you currently taking any medication including psychiatric meds? □ No □ Yes **Please list medication(s) & who is prescribing them** (e.g., family care doctor, psychiatrist, etc.):

____

____

____

Have you ever felt you needed to cut down on your alcohol or drug use? □ No □ Yes

Has anyone criticized your use or shared concerns about it? □ No □ Yes
Have you felt guilty, worried, or stressed about your drinking or drug use? □ No □ Yes

Describe any alcohol or drug related details or concerns:

____

____

____

Do you have any previous diagnoses? □ No □ Yes If so, describe:

____

____

____

Mental health history of family members:

____

____

____

What is your highest level of formal education?

____

Have you had or do you currently have any legal issues? □ No □ Yes
If yes, describe:

____

____

____

What do you consider to be some of your strengths or areas in your life that are going well?

____

____

____

What do you consider to be some of the areas you need to improve?

____

____

____

What do hope to accomplish out of our time in therapy?

____

____

____

Is there anything else I should know about your story, history, or situation?

____

____