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Date of Initial Visit ________________
Client Name____
Home Address____
Street City State Zip
Home Telephone ____________________ Is it okay to call? Yes _____ No _____
Work Phone________________________ Is it okay to call? Yes _____ No _____
Cell Phone ________________________ Is it okay to call? Yes _____ No _____
Social Security Number______________________ Birthdate ___________________ Age _____
Male _____ Female _____ Marital Status S____ M____ W____ D____
Client Status: Employed ______ Full Time Student _______ Part Time Student _______
Highest Degree of Education _________________________________ Religion ____________________
Employer____ Occupation _________________________
Employment Address____
Street City State Zip
Name of spouse ____
Social Security Number______________________ Birthdate ___________________ Age _____
Highest Degree of Education ___________________________ Religion _____________________________
Spouse's employer ______________________________________ Occupation __________________________
Employment Address____
Work Phone________________________ Is it okay to call? Yes _____ No _____
Cell Phone ________________________ Is it okay to call? Yes _____ No _____
Names and ages of children (if applicable): ____
____
Others living in the Home? ____
Person responsible for deductible, coinsurance, and copayments if other than client:______________________
Address ____
Street City State Zip
Did you contact your insurance company to verify your benefits and let them know you were coming?
____
Deductible/year $_________ Has it been met?_______ Copayment/coinsurance/visit $_______ or _____%
Did you receive an authorization number from your insurance company? Yes_____ No_____
Authorization number ____ Number of visits ______
Did you get a referral from your Primary Care Physician if required by your ins. co.? Yes_____ No_____

Insurance Information		For Secondary Ins. Only	
Policy Holder's ID/SS#	____________	Policy Holder's ID/SS#	____________
Ins Co. Name	____________	Ins. Co. Name	____________
Policy Holder's Name	____________	Policy Holder's Name	____________
Relationship to client	____________	Relationship to client	____________
Policy Holder's Address	____________	Policy Holder's Address	____________
	____________		____________
Policy/Group #	____________	Policy/Group #	____________
Policy Holder's DOB	____________	Policy Holder's DOB	____________
Male _____ Female _____		Male _____Female _____	
Employer	____________	Employer	____________

How did you hear about my practice? ____
When you decided to call my practice, where did you get the phone number? ____________________
Nearest relative or friend (not spouse) we can contact in an emergency?

____
Name **Relationship** **Phone**

Client Name____ Date_______________________

Have you received mental health care previously? Yes _____ No_____

If so, name of therapist or group? ____

When? ____

What issues were addressed?

____

____

Have you ever received inpatient psychiatric or alcohol/chemical dependency treatment? ______________

If so, when and where?

____

What issues were addressed?

____

____

In your own words, what issues bring you here at this time?

____

____

Describe any major medical/physical problems:

____

____

How would you describe your physical health at present? Poor Satisfactory Good Excellent

List known allergies:

____

Primary Care Physician_____________________________________ Phone: _______________________

Address ____

Date of last visit _________________

Date of last physical examination _____________

List current medications prescribed by this doctor:

Medication Daily Dose Condition Starting Date

____

____

____

Are you currently disabled? ______________

Psychiatrist, if applicable ___________________________________ Phone: _______________________

Address ____

Date of last visit _________________

List current medications prescribed by this doctor:

Medication Daily Dose Condition Starting Date

____

____

____

____

Client Name: ____ Date: ________________________

Check Any of the Following That May Apply to You:

☐	Headache	☐	Inferiority Feelings	☐	Anger Outbursts
☐	Dizziness	☐	Feel Tense	☐	Increased Irritability
☐	Fainting Spells	☐	Feel Panicky/Panic Attacks	☐	Mood Changes
☐	No Appetite	☐	Fears and Phobias	☐	Obsessions
☐	Over-Eating	☐	Flashbacks	☐	Anxiety/Nervous
☐	Stomach Trouble	☐	Depressed	☐	Always Worried About Something
☐	Bowel Disturbances	☐	Suicidal Ideas	☐	Difficulty Planning Ahead
☐	Always Tired	☐	Feelings of Helplessness and Hopelessness	☐	Memory Problems: short term or long term
☐	Always Sleepy	☐	Impaired Concentration	☐	Short Attention Span
☐	Unable To Relax	☐	Loss of Interest in Activities	☐	Financial Problems
☐	Insomnia	☐	Tearfulness	☐	Gambling
☐	Recurrent Dreams	☐	Difficulty Making Decisions	☐	Spending Sprees
☐	Nightmares	☐	Racing Thoughts	☐	Problems Lying
☐	Hallucinations	☐	Sexual Problems	☐	Work Problems

Other Problems not listed above or comments about the problems identified above:

____

____

____

____

____

____

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never
How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never
When: ____

How often are you having thoughts of harming others presently? Frequently Sometimes Rarely Never
How often have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never
When: ____

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure
When: ____

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank for now)*

Emotional abuse as a child? Physical abuse as a child? Sexual molestation/abuse as a child?

Emotional abuse by a partner/spouse? Physical abuse/assault by a partner/spouse?

Sexual abuse/assault as an adult?

Other Trauma
Specify:____

Do you have any family history of mental health issues?

____
____
____
____
____

AND OTHER DRUG USE ALCOHOL:

How often do you drink alcohol?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

In a typical week, on how many days do you have 4 or more drinks? ___________________________

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

Do you or does someone else think that you may need to cut down or stop using alcohol or drugs?

Yes No Maybe

Have you ever received any type of alcohol or substance abuse treatment?

____
____

Do you have any family history of alcohol or chemical dependency?

____
____
____
____

How much caffeine do you drink per day (coffee, caffeinated sodas, energy drinks, etc.) ?

____

How much do you smoke?

____

How often do you exercise?

____

Please describe your support network (i.e. family, friends, church, etc.) _____________________

____

What are your goals for treatment? What would you like to access through your therapy experience?

____
____
____
____

____

Client Signature Date