CLIENT INFORMATION

Today's date__________

Client Name____

Date of Birth____________________ Age________SS#________________________________

Address____

Street (Apt. #) City State Zip code

Phone numbers: Home ( )____________________ Work ( )____________________

May we call you …at home? Y N …at work? Y N

Cell ( )______________________ **Please circle primary number**

Marital Status: __Single __Married __Separated __Divorced __Widowed __Living Together

Employer/School________________________Occupation______________________________

Family members (please give name and ages of immediate family members)________________

____

____

____

INSURANCE INFORMATION (Please provide your insurance card for photocopying)

Insurance Carrier__________________________ Policy #_____________________________

Subscriber Information: Name__________________________________ DOB______________

Address____ Subscriber SS#____________________

Employer________________________Client's relationship to subscriber__________________

Insurance Company phone number_______________________________

Assignment of Benefits & Release of Information

I hereby assign, transfer and set over to Provider, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until I provide written notice revoking said authorization. I understand that this does not relieve me of my obligation to pay any and all bills if not paid by my insurance company, or of any balance due after payments by my insurance company.

______________________________ ______________________________

Patient/Guardian Signature and date Witness signature and date

Person to be contacted in case of an emergency

Name____________________________________ Home phone number________________

Relationship_______________________________ Work phone number________________

Name___________________________________

Please describe your reasons for seeking counseling (include date difficulties began and any ideas about hurting self/others) ____

____

____

Please indicate how the following areas are being affected:

	No effect	Little	Somewhat	Much	Significantly
Marriage/Relationship	1	2	3	4	5
Family	1	2	3	4	5
Job/School Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Hobbies	1	2	3	4	5
Financial Situation	1	2	3	4	5
Physical Health	1	2	3	4	5
Anxiety level/Nerves	1	2	3	4	5
Mood	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5
Spirituality	1	2	3	4	5

MEDICAL HISTORY

Please list prescription medications you currently use (name, dosage & frequency) __________________________

____

Please list over the counter medications you regularly use (name, dosage & frequency) _______________________

____

Please list any conditions (past or present) that you are (or have been) treated for ____________________________

____

When was your last physical exam?_________________________ By whom? _______________________________

Were there any significant findings? __ Y __ N If yes, please describe __________________________________

Please list any known allergies ____

Please describe any medical or psychiatric conditions of your immediate family ____________________________

____

Please describe your use of the following:

	Current usage	Most ever used
Coffee (cups/day)	______________________	______________________
Cigarettes (packs/day)	______________________	______________________
Alcohol	______________________	______________________

Name ___________________________________

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment of any kind before? __Y __N

If you checked Yes to the above question, please answer the following:

What type of care did you receive? __inpatient (hospital) __outpatient __both
When were you in treatment? ____
Where were you in treatment? ____
How long were you in treatment? ____
Who was your therapist or doctor? ____
Did your doctor prescribe medicine at that time? __Y __ N __Not applicable
If yes, what was prescribed (include dosage if known)? _____________________________

SUBSTANCE USE HISTORY

Have you ever used drugs? __ Y __ N

If yes, please describe ____

____

Have you ever received treatment for alcohol or drug use? __ Y __ N

If yes, please describe ____