

**Client Information**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer \_\_\_\_\_

Address: \_\_\_\_\_

Preferred means of communication ( ) Phone ( ) Email ( ) Text (check all that apply)

Cell Phone: \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number \_\_\_\_\_

**PRESENT SITUATION**

Work: ( ) Full-Time ( ) Part-Time ( ) Student ( ) Unemployed ( ) Retired

May we contact you at work? ( ) Yes ( ) No

May we leave a message for you at home? ( ) Yes ( ) No

Relationship Status: ( ) Single ( ) Partnership ( ) Married ( ) Separated ( ) Divorced

Children names and ages: \_\_\_\_\_

Who lives in your home: \_\_\_\_\_

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

**TREATMENT HISTORY**

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) Yes ( ) No

Have you had previous psychotherapy? ( ) Yes ( ) No, if yes, with (previous therapist)

Are you currently taking prescribed psychiatric medication? ( ) Yes ( ) No

If yes, please list:

\_\_\_\_\_

Prescribed by: \_\_\_\_\_

Prior Hospitalizations or Substance Abuse Treatment: \_\_\_\_\_

Date(s): \_\_\_\_\_

Do you currently have a primary physician? ( ) Yes ( ) No

If yes, who is it? \_\_\_\_\_

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: \_\_\_\_\_

Date of last physical? \_\_\_\_\_

Are you having any difficulty with appetite or eating habits? ( ) Yes ( ) No

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) Yes ( ) No

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

How often do you engage recreational drug use?

( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

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Have you ever experienced any of the following?

Depression	Yes / No
Dramatic mood swings	Yes / No
Racing thoughts	Yes / No
Anxiety	Yes / No
Panic attacks	Yes / No
Risky Activity (speeding, sexual behavior)	Yes / No
Irritability	Yes / No
Avoidance of :	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Impulsivity	Yes / No
Suspiciousness	Yes / No
Alcohol/substance abuse	Yes / No

Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No
Homicidal thoughts	Yes / No
Fatigue	Yes / No
Suicidal attempts	Yes / No If yes, when?

### **FAMILY MENTAL HEALTH HISTORY**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

<b>Difficulty</b>	<b>Yes / No</b>	<b>Family member</b>
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

### **SUBSTANCE HISTORY**

Have you ever tried the following (check all that apply add last date used)

Alcohol ( ) ___/___	Tabacco ( ) ___/___	Marijuana ( ) ___/___	LSD ( ) ___/___
Heroin ( ) ___/___	Meth ( ) ___/___	Cocaine ( ) ___/___	Stimulants ( ) ___/___
Ecstasy ( ) ___/___	Methadone ( ) ___/___	Tranquilizers ( ) ___/___	Pain Killers ( ) ___/___

**Informed Consent rights & Confidentiality and the exceptions.**

We are bound by ethical principles to keep your information confidential, there are exceptions to these principles that you should understand prior to entering into a therapeutic relationship.

1. In case of suspected child abuse, I am required to report this to the appropriate county authorities.
2. If at any point, I believe that your life or someone else’s life is endangered by actions you are about to take, I may break confidentiality to warn or prevent harm to you or another person.
3. If you are using a third party payer (private insurance) I may be required to submit records to your insurer.
4. In some cases, records may be subpoenaed by a judge in custody or litigation.
5. If you are a minor and engage in behaviors that are seriously threatening to your health, this information may be shared with your guardian. I will try to inform you of any decision to divulge this inform before the disclosure of information.
6. To allow any other communication, a written release must be completed and signed by you.
7. Only the custodial or joint custodian can consent to treatment of minors.

**I have read the Informed Consent rights**

\_\_\_\_\_   
 Client Signature

\_\_\_\_\_   
 Date

**I have read the Informed Consent rights**

\_\_\_\_\_   
 Guardian Signature

\_\_\_\_\_   
 Date

**Financial Agreement**

I agree to authorize payment of insurance benefits to provider, authorize release of information necessary to process my claims, and accept payment responsibility for the portion of the bill insurance doesn’t pay within 60 days. I agree to pay in full for all services received. I understand that I am responsible for all charges not covered by my insurance.

\_\_\_\_\_   
 Patient or Guardian Signature

Date: \_\_\_\_\_

**Clinic Policies**

I agree to provide notice of cancellations within 24 hours prior to my appointment. If I fail to provide adequate notice I will be charged full fee with the exception of agreed upon emergencies.

\_\_\_\_\_   
 Patient or Guardian Signature

Date: \_\_\_\_\_

**Insurance Information**

Services are billed by the hour. In accordance with standards of practice. Your insurance is a contract between you and your insurance company. Please present insurance cards to be photocopied.

Primary Insurance Provider \_\_\_\_\_

Member ID \_\_\_\_\_ Group ID \_\_\_\_\_

Policy Holder Full Name \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_

Policy Holder Phone number \_\_\_\_\_ Policy holder SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder Employer \_\_\_\_\_

Insurance contact phone \_\_\_\_\_

**Responsible Party if other than patient: (who is responsible for payment of all costs)**

First Name: \_\_\_\_\_ Middle \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State; \_\_\_\_\_ Zip; \_\_\_\_\_

Phone: \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

**Method of Payment**

Name on Card \_\_\_\_\_

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ CVV \_\_\_\_\_

Card Type: Visa / Mastercard / AmEx

Address attached to card \_\_\_\_\_

\_\_\_\_\_