DX _____

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CONFIDENTIAL CLIENT INFORMATION

TODAY'S DATE_____ **CURRENT MEDICATIONS**_____
_____

CLIENT (INSURED PERSON IF APPLICABLE)
NAME_____ AGE_____ D.O.B._____ EMAIL_____
ADDRESS_____ APT # _____ HOME PHONE_____
CITY _____ ZIP _____ CELL PHONE _____
WORK PHONE_____

INSURANCE POLICY_____
POLICY NUMBER _____

PARENT OR GUARDIAN (IF THE CLIENT IS A DEPENDENT OF AN ADULT)
NAME_____AGE_____ D.O.B_____ EMAIL_____
NAME_____AGE_____ D.O.B._____ HOME PHONE_____
CELL PHONE_____
WORK PHONE_____

CAN I LEAVE A VOICE MAIL ON <u>ALL</u> OF THE PHONE NUMBERS PROVIDED? YES / NO
LIST ANY PHONE NUMBERS THAT ARE <u>NOT OK</u> FOR VOICE MAIL_____

CHECK ALL THAT APPLY FOR CLIENT OR PARENT / GUARDIAN
( ) SINGLE ( ) MARRIED: HOW LONG?_____ ( ) COUPLED, ( )NOT MARRIED:
( ) SEPARATED ( ) DIVORCED: HOW LONG?_____ HOW LONG?
( ) WIDOWED ( ) PREVIOUS MARRIAGES: HOW MANY?_____

PARTNER / SPOUSE (IF CLIENT IS IN A RELATIONSHIP)
PARTNER_____AGE_____ D.O.B._____ EMAIL_____
ADDRESS_____ APT #_____HOME PHONE_____
CITY_____ ZIP_____ WORK PHONE_____
CELL PHONE _____

CHILDREN OF CLIENT OR IN THE HOME
NAME_____ D.O.B._____ M/F
NAME_____ D.O.B._____ M/F
NAME_____ D.O.B._____ M/F
NAME_____ D.O.B._____ M/F
NAME_____ D.O.B._____ M/F
NAME_____ D.O.B._____ M/F

FINANCIALLY RESPONSIBLE PARTY *IF OTHER THAN YOURSELF:* _____
RELATIONSHIP TO CLIENT:_____

FINANCIAL RESPONSIBILITY:
I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED.

X_____
Signature of Responsible Party Date

PLEASE DESCRIBE ANY PRIOR THERAPY OR PSYCHIATRIC HOSPITALIZATIONS YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM:

_____
_____

PLEASE LIST ANY PREVIOUS OR CURRENT SUICIDAL THOUGHTS, PLANS, ATTEMPTS HOSPITIALZATIONS:

_____ _____
_____

PLEASE DESCRIBE THE PRESENT PROBLEM:

_____
_____
_____
_____

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY:

_____
_____
_____
_____

PLEASE DESCRIBE ANY HEALTH PROBLEMS:

_____
_____
_____
_____

TRAUMA HISTORY AND OR RECENT DEATHS / LOSSES: (IF WRITING THIS IS TRIGGERING YOU ARE WELCOME TO LEAVE IT BLANK)

_____
_____
_____
_____

TRAUMA THAT OCCURRED FROM BIRTH TO AGE 2: (I.E. PREMATURE, INJURIES, MEDICAL, CHORD WRAPED AROUND YOUR NECK ECT…)

_____
_____
_____
_____

SPIRITUAL OR RELIGIOUS AFFILIATIONS:

_____
_____

DO YOU DRINK ALCOHOL: YES/NO SPOUSE / PARTNER: YES/NO
WHAT KIND / HOW MUCH / HOW OFTEN:_____

DO YOU USE ANY OTHER SUBSTANCES: YES/NO SPOUSE / PARTNER: YES/NO
WHAT KIND / HOW MUCH / HOW OFTEN:_____
(IE. MARIJUANA, COCAINE, ETC.)

ARE YOU TAKING ANY MEDICATION: YES/NO SPOUSE / PARTNER: YES/NO
DESCRIBE_____

DO YOU HAVE ANY TROUBLE SLEEPING: YES/NO SPOUSE / PARTNER: YES/NO
DESCRIBE_____

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS: YES/NO
DESCRIBE_____

NAME OF PHYSICIAN_____ DATE OF LAST PHYSICAL EXAM_____

FAMILY MENTAL HEALTH HISTORY:
IN THE SECTION BELOW IDENTIFY IF THERE IS A FAMILY HISTORY OF ANY OF THE FOLLOWING. IF YES, PLEASE INDICATE THE FAMILY MEMBER'S RELATIONSHIP TO YOU IN THE SPACE PROVIDED *(FATHER,GRANDMOTHER, UNCLE, ETC.).*

	PLEASE CIRCLE	LIST FAMILY MEMBER
ALCOHOL/SUBSTANCE ABUSE	YES/NO	_____
ANXIETY	YES/NO	_____
DEPRESSION	YES/NO	_____
DOMESTIC VIOLENCE	YES/NO	_____
EATING DISORDERS	YES/NO	_____
OBESITY	YES/NO	_____
OBSESSIVE COMPULSIVE BEHAVIOR	YES/NO	_____
SCHIZOPHRENIA	YES/NO	_____
SUICIDE ATTEMPTS	YES/NO	_____

IS THERE ANY OTHER INFORMATION THAT WOULD BE HELPFUL FOR ME TO KNOW?:
_____
_____
_____
_____
_____
_____

REV. 02/05/2015