Joseph E. Broome, MA, LMHC
Individual, Teen &Family Therapy
Washington Mental Health Counselor License # LH60200686
www.InItTogether.org
206.295.0624
In It Together L.L.C.

CONFIDENTIAL CLIENT INFORMATION

INTAKE 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/I
NAME_____ D.O.B._____ M/F/I
NAME_____ D.O.B._____ M/F/I
NAME_____ D.O.B._____ M/F/I
NAME_____ D.O.B._____ M/F/I
NAME_____ D.O.B._____ M/F/I

FINANCIALLY RESPONSIBLE PARTY *IF OTHER THAN CLIENT:* _____
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. 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:

PLEASE LIST THE GOALS OF 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:

GENDER AND SEXUAL IDENTITIES:

RACIAL AND CULTURAL IDENTITIES:

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?
_____
_____
_____
_____
_____
_____

Credit and Debit Card Payment Agreement

Client: _____

Credit or Debit Card Information

Credit / Debit Card: Visa MC American Express
(Circle One)

Name on Card: _____

Billing Zip Code: _____

Card Number: _____-_____-_____-_____

Expiration Date: _____

Security Code or PIN: _____

I understand that credit information will be kept on file with Joe Broome, LMHC, In It Together Therapy, and that each transaction is subject to obtaining an authorization number from the corresponding bank which holds the card. My card will be charged for the client responsibility balance due unless otherwise specified.

My signature below authorizes Joe Broome, LMHC and In It Together Therapy to utilize this payment method as specified above.

X_____

Date_____

IN IT TOGETHER
BETTER LIVING THROUGH BETTER RELATIONSHIPS