Client Information

Contact information

Name: _____

Birthdate: _____ Today's Date: _____

Address: _____

_____

Email: _____

Phone numbers (please circle your preferred number)

Cell: _____ ☐ OK to leave message?

Home: _____ ☐ OK to leave message?

Your preferred way of contact: cell ❑ or email ❑

Emergency contact

Name: _____

Relationship: _____

Phone Number: _____

What issues/concerns cause you to seek treatment? Please describe:

_____

_____

Do you have any specific goals with regard to your treatment: _____

_____

Education or Degrees/certificates completed: _____

If you would like a Super Bill provided to you for insurance purposes, please provide an email address where you can receive invoices: _____

Background

Referred by: _____

Have you had therapy/counseling before? If yes, with whom, where and when:

_____

Please list everyone and their ages with which you presently live: _____

_____

_____

Relationship Status: Single ❑ Cohabitation ❑ Married ❑ Separated ❑ Divorced ❑

Occupation: _____

Is spirituality important to you: ❑ not at all ❑important ❑very important

If important, name of church/temple/mosque you attend: _____

To whom do you turn to forsupport: _____

Name your strengths and hobbies: _____

History

Are you currently taking medication for emotional or mental issues: _____

If so, please list your medication, dosage and your prescribing doctor:

_____

_____

Have you been hospitalized for a mental illness:_____if yes, please describe:

_____

_____

Have you ever been diagnosed with a serious illness?_____If yes, please describe: _____

_____

Number of pregnancies:_____Number of abortions: _____

Check any symptoms you have exhibited in the past six months:

_____Sadness/Crying Spells
_____Socially Isolated
_____Appetite /Weight Gain or Loss
_____Excessive Sleep
_____Persistent Thoughts
_____Giving Up Easily
_____Difficulty Having Fun
_____Excessive Anger/Hostility
_____Nervousness/Jittery
_____Irritable/Temper Outbursts
_____Insomnia
_____Mood Swings
_____Excessive Worrying
_____Excessive Nightmares
_____Panic Attacks
_____Self-Mutilation

_____Suicidal Thoughts/Statements _____Overeating/binging
_____Sexual Dysfunction _____Lethargy

0ther (please describe): _____

_____

Are you at the present time using any type of chemical substance?_____If yes, please indicate what you are using (drugs and/or alcohol): _____

_____

Family history of mental health concerns:(including depression, anxiety, ADHD, eating disorder, bipolar, schizophrenia, suicide, drug/alcoholproblems) _____

_____

Please add any other information you believe would be helpful for me to know: _____

_____

_____

Financial Agreement and Authorization for Treatment of a Minor

I authorize treatment for my minor child and attest that I am the legal guardian, *solely and legally* able to obtain treatment for this child, and can produce required documentation.

_____

Signature Relationship to minor Date

_____

Signature Relationship to minor Date

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family when services are rendered. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

_____

Signature Date

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