

## 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 for support: \_\_\_\_\_

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

\_\_\_\_\_ Nervousness/Jittery

\_\_\_\_\_ Socially Isolated

\_\_\_\_\_ Irritable/Temper Outbursts

\_\_\_\_\_ Appetite /Weight Gain or Loss

\_\_\_\_\_ Insomnia

\_\_\_\_\_ Excessive Sleep

\_\_\_\_\_ Mood Swings

\_\_\_\_\_ Persistent Thoughts

\_\_\_\_\_ Excessive Worrying

\_\_\_\_\_ Giving Up Easily

\_\_\_\_\_ Excessive Nightmares

\_\_\_\_\_ Difficulty Having Fun

\_\_\_\_\_ Panic Attacks

\_\_\_\_\_ Excessive Anger/Hostility

\_\_\_\_\_ Self-Mutilation

\_\_\_\_\_ Suicidal Thoughts/Statements  
\_\_\_\_\_ Sexual Dysfunction

\_\_\_\_\_ Overeating/binging  
\_\_\_\_\_ Lethargy

Other (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/alcohol problems) \_\_\_\_\_

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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