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CLIENT INFORMATION

Client Name: _____ Today's Date _____

Birthdate: _____/_____/_____ Age _____ Male Female SS# _____-_____-_____

Street Address _____ City _____

State _____Zip Code _____ Home No.(__)_____

Cell/Alt. No. (____) _____ Work No.(___)_____ Ok to call/mssg? YES NO

Email address: _____Ok to leave message on home phone? YES NO
Ok to leave message via text? YES NO
Ok to leave a message via email? YES NO

Employer/School _____ Occupation _____

Marital Status o Single o Married o Separated o Divorced o Widowed o Living Together

How Long? _____ Spouse/Partner's Name _____

Previous Marriage? Yes No How Long? _____

Children Names/Ages _____

Emergency Contact _____Phone No. (____)_____

Relationship to You _____ ok to call in an emergency? YES NO

Previous Counseling? Yes No Past Therapist(s) _____

Referred by _____ _ Ok to send thank you? Yes No

Primary Physician _____ Date Last Seen _____

Physician's Phone No.(____) _____ Physician's Fax No. (____) _____

Release on file? Yes No Medical History: _____

Current Medications: _____

Insurance Yes No Do you have a Deductible? Yes No Have you met deductible? Yes No

Primary Insurance _____Policy # _____

Insurance Phone No.(s) (____) _____ Group # _____

Subscriber's Name _____ Subscriber SS#/Member # _____

Secondary Insurance _____ Policy # _____

Insurance Phone No.(s) (_____) _____ Group # _____

Subscriber's Name _____ Subscriber SS#/Member # _____

Presenting Concern: Please describe your primary reason seeking treatment at this time. _____

_____

Was there an event which caused these problems? Yes No If Yes, Please Describe _____

_____

Pre-Treatment Survey -Please rate how much you were affected by the following in the past month.

	N/A	Mildly	Moderately	Severely
Nightmares/Flashbacks				
Concerns about your body of physical health				
Thoughts or behaviors you do over and over again				
Unusually high energy				
Feeling sad, blue, or depressed				
Anxiety, "nerves", or tension				
Anger, hostility, or irritability				
Fears of things or places				
Beliefs that others want to hurt you				
Drinking too much or using drugs				
Thoughts of Hurting Yourself or Others				
Relationship Conflict				
Prior suicide attempts	Yes _____ No _____			
Prior emotional/sexual/physical abuse	Yes _____ No _____			
Ever diagnosed with a serious illness	Yes _____ No _____			
Prior or currently involved in a lawsuit	Yes _____ No _____			
Other: _____				

Please rate how well you are doing:

	Cannot Function	Serious Problems	Moderate Problems	Mild Problems	No Problems
On your job/school					
In your marital/significant other relationship					
In your family relationships					
In relationships with people outside your family					

Please help us evaluate our services to you by rating the following:

	Excellent	Very Good	Good	Fair	Poor
Promptness of scheduling your appointment with your therapist					
Ease of getting to your therapist's office					

(Initial) _____ You have my permission to contact insurance to confirm benefits.

(Initial) _____ You have my permission to treat me/my minor child.

(Initial) _____ I assign any insurance benefits to be paid to PROVIDERS NAME and agree to pay any remaining balance.

_____

Client Signature Date

_____

Parent/Guardian (if Minor) Date