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Thank you for choosing our practice. If you have any questions or need assistance, please contact us. Please print legibly, thank you.

Client Information

Client Name _____

Date of Birth _____

SS#_____ Age _____ Gender _____

Is the client a minor? YES NO If Yes, Parent or Guardian's Name _____

If the client is a minor, in the case of separation or divorce, which parent has legal custody? _____

Home Address _____

Home Phone _____ Cell Phone_____ Work Phone _____

Do we have permission to leave messages on your voicemail? YES NO

Email Address _____

Please indicate your preferred method of contact:

Cell Phone Home Phone Work Phone

Text Message Email

Referral Source _____

May we add your email to our newsletter? YES NO

Responsible Party

Please indicate the following information regarding the person who is financially responsible for this account. If the client is a minor, the parent bringing the child in for services is considered the responsible party.

Name of Responsible Party _____

Relationship to Client _____

Date of Birth _____

SS# _____

Address _____

Employer _____

Occupation _____

Cell Phone_____Home Phone_____Work Phone_____

Emergency Contact Information

In case of emergency, who should we contact:

Name_____

Phone _____

Relationship to the client _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Address of Insured _____

Phone # of Insured _____

DOB of Insured _____

SS# _____

Employer _____

Occupation _____

Insurance Company _____

Policy #_____ Group #_____

Insurance Company Contact Phone #_____

Do you have Out-of-Network Benefits? YES NO If so, what are they? _____

_____

An invoice will be provided to you to be reimbursed directly by your insurance company should you have out-of-network benefits. Please note it is the client's responsibility to confirm OON benefits and submit all necessary documentation for reimbursement.

Clients are responsible for all expenses incurred. Please read your policy carefully and/or contact your insurance provider so that you are fully aware of your coverage and any limitations of the benefits provided.

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

X_____

Signature of client or parent/guardian of minor Date

Cancellation Policy

Your session time is reserved specifically for you. As a courtesy to other clients and staff, please provide 24-hours notice in the case of a cancellation. We charge the full session fee for any missed appointment or appointment cancelled with less than 24-hours notice. This fee is not reimbursable with your healthcare provider. A credit card will be kept on file and charged should there be a missed session.

Initial here X_____

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Client Information Sheet

Client Name _____ Age_____

Marital Status: Child Single Adult Married Divorced Widowed

History of Presenting Problem - Please describe your reason for seeking treatment at this time, or why treatment has been recommended.

_____

_____

_____

_____

How long have you had this problem (when did it begin)? _____

Have you previously received any type of mental health services? If so, please indicate below:

		Provider Name	Dates of Service
Outpatient counseling	YES NO		
Psychiatric Emergency Screening Services	YES NO		
Inpatient Psychiatric Hospital Stay	YES NO		
Drug/Alcohol Rehabilitation	YES NO		
Therapeutic Residential Program	YES NO		
Partial Hospitalization Program	YES NO		

Intensive Outpatient Program	YES NO		

Are you currently receiving treatment by a Psychiatrist or APN for medications? YES NO

If so, please provide their contact information:

Name:_____Phone:_____

Medical History

Are you receiving medical treatment for any condition now or within the past year? YES NO

If Yes, please explain: _____

_____

Current Primary Physician: _____ Phone:_____

Are you currently taking any prescription medications or supplements? If so, please list below:

Medication	Dose	Reason	Prescriber

Social History

Highest Grade Completed in School _____Where_____

Are you currently employed: YES NO

Employer:_____Position: _____

Do you enjoy your work? Are there any current work related stressors? _____

_____

Please list household members and ages: _____

_____

_____

Use of Alcohol: Never Rarely Moderately Daily

Use of Drugs (including prescription pain medicine): Never Rarely Moderately Daily

Type of drugs used:_____

History of Legal Charges or Arrests: YES NO

If YES, please explain:_____

_____

Do you have any history of the following:

		Please explain
Victim or Witness to Sexual Abuse	YES NO	
Victim or Witnessed Domestic Violence	YES NO	
Suffered a Traumatic Experience	YES NO	
Suicide Attempts	YES NO	

Currently experiencing suicidal thoughts: YES NO If Yes, please explain:_____

_____

Currently engaging in non-suicidal self-injury? : YES NO If Yes, please explain:_____

_____

Have you experienced any major life changes lately? Please circle any that apply:

Move/Relocation Change of School Separation/Divorce

Birth of a Child Catastrophic Illness Unemployment/Financial Issues

Trauma Victim of a Crime Loss/Death

Other_____

DCPP Involvement? YES NO If Yes, Please explain: _____

DCPP Case Manager:_____Phone:_____

How would you describe your mood most of the time? Please circle any that apply:

Cheerful/Happy Anxious/Nervous Sad/Depressed Angry/Irritable

Mood Varies Numb/Unfeeling Other_____

How would you rate your physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any current health concerns_____

Are you currently experiencing any chronic pain? YES NO Please explain_____

How would you rate your current sleep habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

How many hours sleep do you usually get per night? _____

Please list any current sleep concerns_____

How often do you exercise? _____

What type of exercise do you participate in? _____

Do you currently have any difficulties with appetite or eating patterns? YES NO

Do you have any history of eating disorders or body image issues? YES NO

Please explain _____

Family Mental Health History: Please identify if there is a family history of any of the following. If Yes, please list the family members relationship to you (i.e. paternal grandmother, father, aunt, etc.)

	Please Circle	Family Member
Alcohol/Substance Abuse	YES NO	
Anxiety	YES NO	
Bipolar Disorder	YES NO	

Depression	YES NO	
Domestic Violence	YES NO	
Eating Disorders	YES NO	
Schizophrenia	YES NO	
Suicide Attempts	YES NO	

Do you consider yourself to be spiritual or religious? YES NO

If so, please describe your faith/beliefs: _____

_____

What do you consider your strengths?

_____

What do you consider your weaknesses?

_____

What would you like to accomplish during your time in therapy?

_____

_____

_____

_____

On a scale of 1 to 10, how motivated are you to work on these therapeutic goals? _____

If the client is a minor, are both parents/guardians in agreement regarding the child's need for treatment?

YES NO

Is there any additional information you feel is important for us to know at this time?

_____

_____

Thank you for taking the time to respond so we can better meet your needs.