

Today's Date ____/____/____

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Divorced / other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)	Birth Date / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security - -		Home Phone No. ()
P.O. Box		City	State	ZIP Code			Cell Phone No. ()
Occupation		Employer				Work Phone No. ()	

Referred to Provider by (Please check one box & list) Dr. _____ Insurance Plan Website

Family Friend Close to Home/Work Yellow Pages Other _____

Email Address: _____ Alternative Email Address: _____

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)		Home Phone No. ()	
Email Address:				Cell Phone No. ()	
Occupation	Employer	Employer Address		Work Phone No. ()	
Is this client covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Annual EAPs allowed? _____	
What is exact name of insurance?					
What is the authorization number?				<input type="checkbox"/> Self Pay	
Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Client's Relationship to Insured		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of Secondary Insurance (if any)		Insured's Name		Group #	Policy #
Client's Relationship to Insured		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Please answer the following questions that may be relevant to therapy:

Please note: information you provide here is protected as confidential information.

1. Do you have any medical conditions being treated by a physician? ____yes ____no

If yes, please note condition and dates of treatment.

2. Are you currently taking medication? ____yes ____no

If yes, please specify type and dosage.

3. Have you previously attended therapy sessions? ____yes ____no

If yes, when? And for how long?

4. Do you have any history of suicidal ideation or suicide attempt? ____yes ____no

If yes, please explain.

5. Are you currently experiencing overwhelming sadness, grief or depression?

____yes ____no

If yes, please describe and for how long.

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ____yes ____no

If yes, please describe and for how long.

7. How often do you drink alcohol/week (including beer and wine)?

8. How often do you engage in recreational drug use?

9. What significant life changes or stressful events have you experienced recently?

10. What else would you like me to know about you?