

**INFORMATION AND HISTORY**

Some of the following questions will provide basic information for insurance purposes, other questions will help us to focus during the initial interview. Please complete thoroughly.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_

	OK to leave a message?	Which is preferred number?
Telephone: _____ (Home)	Y N	<input type="checkbox"/>
_____ (Work)	Y N	<input type="checkbox"/>
_____ (Mobile)	Y N	<input type="checkbox"/>

Your Employer & Position: \_\_\_\_\_ How Long? \_\_\_\_\_

Highest Education Completed: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_ (If yellow pages, which book? \_\_\_\_\_)

To whom will bills be sent (after insurance)? \_\_\_\_\_ Relationship? \_\_\_\_\_

Address & Telephone (if different than the patient's): \_\_\_\_\_

Contact in case of emergency (name & phone) ? \_\_\_\_\_ Relationship? \_\_\_\_\_

**INSURANCE INFORMATION (if applicable):**

**Policy #1**

Who is the Insured Party? \_\_\_\_\_ Relation to You: \_\_\_\_\_

(If not you) Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy ID # \_\_\_\_\_

Address for Claims: \_\_\_\_\_ Group # \_\_\_\_\_

Employer: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Policy #2**

Who is the Insured Party? \_\_\_\_\_ Relation to You: \_\_\_\_\_

(If not you) Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy ID # \_\_\_\_\_

Address for Claims: \_\_\_\_\_ Group # \_\_\_\_\_

Employer: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**HOUSEHOLD & MISC. INFORMATION:**

People Currently Living with You:

Name	Relationship	Age

Are you currently on Probation, Parole, or have any legal charges pending?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you currently involved in any legal proceedings (eg, a civil suit, divorce, custody case, bankruptcy, etc)?  Yes  No

If yes, please explain: \_\_\_\_\_

Is an evaluation or participation in psychotherapy required of you by anyone (eg, court or employer)?  Yes  No

If yes, who? \_\_\_\_\_

**MEDICAL INFORMATION:**

Current Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

May I contact your primary physician to coordinate care if necessary?  Yes  No

If yes, please sign here to authorize: \_\_\_\_\_

Any current Medical Problems?: \_\_\_\_\_  
 \_\_\_\_\_

Current Medications and dosages: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List Below Any Significant Medical History (illnesses, operations, conditions):

**MENTAL HEALTH HISTORY:**

Are you currently in counseling or receiving mental health or substance abuse services from any other provider? \_\_\_\_\_

Have you ever received counseling, mental health or substance abuse services in the past? \_\_\_\_\_

If so, please list below:

Approx. Dates	Provider or Institution Name	Reason

Have you ever taken medication for psychiatric reasons in the past? \_\_\_\_\_ If so, please list below:

Approx. Dates	Name of Medication	Reason

Have you ever had Psychological Testing? \_\_\_\_\_ If so, approximately when and where?

Has anyone in your family had, or been in counseling or treatment for, a mental health or substance abuse condition? \_\_\_\_\_

If so, please list below:

Relation	Condition and/or Treatment

I have completed this form with information that is true and accurate to the best of my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If a minor:  
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_