

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: _____

Telephone: _____ (Home)	OK to leave a message? Y N	Which is preferred number? <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: _____