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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	☐
_____	(Work)	Y	N	☐
_____	(Mobile)	Y	N	☐

Email: _____ (primarily for scheduling)

Your Employer & Position: _____ How Long? _____

Highest Education Completed: _____

How did you hear about me? _____

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: _____