BACKGROUND INFORMATION

Client 18 or over: Today's Date: _____

Name _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Telephone (day) _____ (evening) _____

May I leave a message for you at home? Yes ____ No ____ May I leave a message at work? Yes ____ No ____

Emergency Notification _____ Relationship _____ Phone _____

Children (names/ages) _____

Marital Status single _____ married _____ divorced _____ separated _____ other _____

Occupation _____ Employer _____

Social Security # _____ Education _____

How did you hear about me? _____ E-mail _____

MEDICAL INFORMATION

Your Physician _____ Date/last exam _____

Prescription/Non-Prescription medication(s) you are currently taking:

Name of Medication	Dosage	Date of Initial Rx
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past/current medical problems/surgeries _____

_____

Please describe the following as it applies to you:

Frequency/quantity of alcohol consumption _____

Quantity of cigarette smoking _____

Amount of caffeine consumption _____

Frequency/type of physical exercise _____

Amount/quality of sleep _____

Please describe any allergies you have _____

Weight _____ Height _____ Race/Ethnicity _____

OVER

PREVIOUS THERAPY EXPERIENCE:

Have you ever been in therapy before? Yes ___ No___ If yes, please describe below:

1) Name of therapist _____ Dates _____

Type/effectiveness of treatment _____

2) Name of therapist _____ Dates _____

Type/effectiveness of treatment _____

Previous psychiatric hospitalizations? _____

CURRENT PROBLEMS:

Please describe briefly what changes you are hoping to make by coming to therapy now. _____

_____

_____

_____

Please mark only the symptoms below which you have experienced in the past 3 months. Rate the intensity from 1 to 3, with 3 being the most severe.

__Depression	__Feeling hopeless	__Obsessions or compulsions
__Extreme sadness	__Trouble concentrating	__Change in sleeping habits
__Memory problems	__Lack of energy	__Change in eating habits
__Weight changes	__Feeling stressed	__Feelings of extreme happiness
__Self-esteem problems	__Easily irritated	__Change in sexual interest or function
__Perfectionism	__Feeling guilty	__Problems getting along with family
__Problems with anger	__Feeling Fearful	__Trouble performing your job
__Feeling anxious	__Acting violently	__Lack of enjoyment of usual activities
__Feeling tearful	__Muscle tension	__Sudden feelings of panic
__Physical complaints of pain	__Thoughts of hurting yourself/others	__Thoughts of killing yourself/others

__Other: _____

_____

INSURANCE INFORMATION: **Please be sure to include photocopy of both sides of your insurance card.**

Name & Mailing Address of Insurance Company _____

_____ phone _____

Name of Insured _____Employer _____

Relationship to Insured _____ **Insured's** ID/SSN# _____ Group # _____

I authorize payment of medical benefits to the provider of services, and the release of any treatment information necessary to process claims or obtain authorizations for treatment:

Signature _____ Date _____

BACKGROUND INFORMATION

Client Under 18: Today's Date: _____

Client Name _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Parent Name _____

Parent Address _____ City _____ State _____ Zip _____

Parent Telephone (day) _____ (evening) _____

May I leave a message for you at home? Yes _____ No _____ May I leave a message at work? Yes _____ No _____

Emergency Notification _____ Relationship _____ Phone _____

Siblings (names/ages) _____

Social Security # _____ Education _____

Client Phone # (if different from above) _____ May I leave a message for you? Yes ___ No ___

How did you hear about me? _____ E-mail _____

MEDICAL INFORMATION

Client's Physician _____ Date/last exam _____

Prescription/Non-Prescription medication(s) Client is currently taking:

Name of Medication	Dosage	Date of Initial Rx
_____	_____	_____
_____	_____	_____
_____	_____	_____

Client's past/current medical problems/surgeries _____

_____

Please describe the following as it applies to the Client:

Frequency/quantity of alcohol consumption _____

Quantity of cigarette smoking _____

Amount of caffeine consumption (incl. soda pop) _____

Frequency/type of physical exercise _____

Amount/quality of sleep _____

Please describe any allergies Client has _____

Weight _____ Height _____ Race/Ethnicity _____

OVER

CLIENT'S PREVIOUS THERAPY EXPERIENCE:

Has Client ever been in therapy before? Yes ___ No___ If yes, please describe below:

1) Name of therapist _____ Dates _____

Type/effectiveness of treatment _____

2) Name of therapist _____ Dates _____

Type/effectiveness of treatment _____

Previous psychiatric hospitalizations? _____

CLIENT'S CURRENT PROBLEMS:

Please describe briefly what changes you are hoping to make by coming to therapy now. _____

_____

_____

_____

Please mark only the symptoms below which you (Client) have experienced in the past 3 months. Rate the intensity from 1 to 3, with 3 being the most severe.

__Depression	__Feeling hopeless	__Obsessions or compulsions
__Extreme sadness	__Trouble concentrating	__Change in sleeping habits
__Memory problems	__Lack of energy	__Change in eating habits
__Weight changes	__Feeling stressed	__Feelings of extreme happiness
__Self-esteem problems	__Easily irritated	__Change in sexual interest or function
__Perfectionism	__Feeling guilty	__Problems getting along with family
__Problems with anger	__Feeling Fearful	__Trouble performing your job/studies
__Feeling anxious	__Acting violently	__Lack of enjoyment of usual activities
__Feeling tearful	__Muscle tension	__Sudden feelings of panic
__Physical complaints of pain	__Thoughts of hurting yourself/others	__Thoughts of killing yourself/others

__Other: _____

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