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Your answers to these questions are confidential. Please ask me any questions you may have in filling out the form.

1. Date: _____ 2. Full Name: _____

3. Date of Birth: _____ 4. Social Security #: _____

5. Occupation: _____

6. Address – may I send mail to you here? YES NO

Street: _____

City/St/Zip: _____

7. Phone #s – may I leave a message at this #?

Day: _____ YES NO

Eve: _____ YES NO

Cell: _____ YES NO

8. Medical Insurance Co: _____ Subscriber #: _____

Insurance contact person: _____ Insurance Phone #: _____

9. Email Address: _____ May I email you? YES NO

10. Primary Care Physician: _____ Phone: _____

10a. Date of last physical exam: _____

11. Do you currently see a psychiatrist? YES NO

Name: _____ Phone: _____

May I contact your physician(s) if necessary? YES NO

Please provide your signature indicating your consent: _____

12. List any health problems for which you currently receive treatment or have received treatment in the past.

13. List any medications (prescription or non-prescription) you are currently taking.

Type	Dose	Reason
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_____	_____	_____
_____	_____	_____
_____	_____	_____

14. How were you referred to me?

15. Previous counseling experience? YES NO

Dates

Therapist's Name

16. Please indicate current use and frequency of use of the following substances:

	More than once a day	Once a day	Every 2-3 days	Weekly	Monthly	Yearly or less	Never
Alcohol							
Non- prescription Drugs							
Nicotine							
Caffeine							
Prescription Drugs							

17. Who else lives in your household? What is their relationship to you?

18. Please state the reason(s) you are seeking therapy.

19. How many sessions do you think it might take to address your concerns?

20. Person to contact in case of emergency:

Name: _____ Phone: _____

Thank you!