

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

1. Today's date: _____ 2. Full name _____

3. Date of birth _____ 4. Social security # _____

5. Occupation _____

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

Street: _____

City/St/Zip: _____

Email: _____

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. Primary Care Physician's name: _____ Phone: _____

9a. Date of last physical exam: _____

10. 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 _____

11. If school-age child, please indicate school attending and school counselor's name (if applicable) _____

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
_____	_____	_____
_____	_____	_____

(Medication – continued)

14. Who referred you to me? _____

15. Previous counseling/therapy? 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	Once 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? Their relationship to you?

18. Please state the reason/s you are seeking help

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

20. Person to contact in case of emergency?

Name:

Phone:

Relationship: