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Please complete one form per adult.

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: _____ _____

7. Phone #s – may I leave a message at this #? Day: _____ YES NO Eve: _____ YES NO Cell: _____ YES NO
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8. Medical Insurance Co: _____ Subscriber #: _____ Insurance contact person: _____ Insurance Phone #: _____
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Email Address: _____ May I email you? YES NO

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

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

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

13. How were you referred to me? _____

14. Previous counseling/therapy? YES NO

Dates	Therapist's Name
_____	_____
_____	_____
_____	_____

15. 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							

16. Who else lives in your household? Their relationship to you?

17. Please state the reason/s you are seeking therapy.

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

18. Person to contact in case of emergency?

Name:

Phone:

Relationship:

Thank you.