

Client Information

Client's name: \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Sexual orientation: \_\_\_\_\_

To which cultural/ethnic group(s) do you belong: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer (if applicable): \_\_\_\_\_

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (mobile) \_\_\_\_\_ (work)

Email: \_\_\_\_\_

**CONTACT INFORMATION**

OK to send snail mail?  Yes  No OK to email?  Yes  No  
OK to call?  Yes  No OK to leave message?  Yes  No What is the preferred number? \_\_\_\_\_

Please provide an answer to a security question that only you and I will know so that I can send you encrypted email.  
Sample security questions include: 1) what is the name of the street you grew up on? 2) what is your favorite food?  
3) what was your high school mascot? 4) other "favorite" question? \_\_\_\_\_

Your answer to security question identified above: \_\_\_\_\_

Please provide a name and phone number of whom to call in case of an emergency: \_\_\_\_\_  
\_\_\_\_\_

**PAYMENT INFORMATION**

Private Pay:  Yes  No Fee Pay Rate: \$185/50 minute intake; \$150/45 minute regular session

\*If not private pay, Insurance Name: \_\_\_\_\_

*\*You are responsible for payment of charges incurred, regardless of whether your insurance company decides to honor this claim.*

Co-pay or Co-insurance: \$ \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Birth Date of Policy Holder: \_\_\_\_\_

Address of Policy Holder: \_\_\_\_\_

Policy Holder I.D. Number: \_\_\_\_\_

Policy Holder Group Number: \_\_\_\_\_

Client Signature indicating that you understand and agree to this payment arrangement: \_\_\_\_\_

Will you be requesting a bill and/or a receipt? Is it for insurance or for a flex spending plan? (Please circle one.)

**REFERRAL INFORMATION**

Who referred you to me or how did you hear of my practice? \_\_\_\_\_

May I have your permission to contact this person to thank him or her for the referral?  yes  no

**Current reason(s) for seeking therapy:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please estimate the degree of difficulty experienced in each area by marking each item with the appropriate number:  
1 = no difficulty 2 = mild difficulty 3 = moderate difficulty 4 = severe difficulty 5 = very severe

\_\_\_\_\_ job/school      \_\_\_\_\_ family relationships      \_\_\_\_\_ friendships      \_\_\_\_\_ partner/relationship  
\_\_\_\_\_ food/body image      \_\_\_\_\_ violence/abuse/trauma      \_\_\_\_\_ alcohol/drug use  
\_\_\_\_\_ medical condition      \_\_\_\_\_ life transition(s)      \_\_\_\_\_ grief/loss      \_\_\_\_\_ sexual identity  
\_\_\_\_\_ other (specifically: \_\_\_\_\_)

Seeking counseling to help with (check all that apply):

coping       anxiety       depression       fear/phobias       eating disorder  
 sleeping problems       addictive behaviors       career concerns       existential concerns  
 sexual concerns       other (specifically: \_\_\_\_\_)

I have had an unwanted sexual experience:  never  recently  in the past  unsure

I consider my unwanted sexual experience to be:  rape  incest  sexual assault  other

I am dissatisfied with my personal appearance:  yes  no

I have tried to control my weight  recently  in the past

With:  vomiting  no eating/dieting  laxatives  excessive exercise  diet pills  diuretics

## FAMILY INFORMATION

Who currently lives with you in your home or is a part of your immediate family?

<u>Name</u>	<u>Age</u>	<u>Relationship (i.e., parent, spouse, partner, child, pet, etc.)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your mother still living?  Yes  No

Is your father still living?  Yes  No

Are your parents (circle all that apply): Married to each other    Divorced/separated    Remarried    Never married

Special circumstances (e.g., raised by person other than parent(s), information about spouse/children not living with you, etc.): \_\_\_\_\_

Is there any alcohol or drug abuse in your current home that concerns you?  Yes  No  Unsure

Is there any violence or other abuse in your current home that concerns you?  Yes  No  Unsure

Was there any alcohol or drug abuse in your home growing up?  Yes  No  Unsure

Was there any violence or physical abuse in your home growing up?  Yes  No  Unsure

Was there any violence or sexual abuse in your home growing up?  Yes  No  Unsure

Was there any verbal abuse in your home growing up?  Yes  No  Unsure

Other childhood circumstances (such as neglect or inadequate nutrition, trauma, frequent moves, parent death, etc.) that affected your development? \_\_\_\_\_

How would you describe your relationship with your mother?  Good  Fair  Poor  Non-existent

How would you describe your relationship with your father?  Good  Fair  Poor  Non-existent

Relationship status (more than one answer may apply):

single  legally married (for # \_\_\_\_\_ yrs)  unmarried, living together (for # \_\_\_\_\_ yrs)

divorce in process (length of time: \_\_\_\_\_ yrs)  divorced (length of time: \_\_\_\_\_ yrs)

annulment: (length of time: \_\_\_\_\_ yrs)  widowed: (length of time: \_\_\_\_\_ yrs) Total # of marriages: \_\_\_\_\_

Assessment of current relationship (if applicable):  good  fair  poor

**SOCIAL INFORMATION**

How easy it is for you to make friends? very difficult somewhat difficult fairly easy very easy  
How supportive/trustworthy do you feel your friends are? very somewhat a little not at all  
Check how you generally get along with other people: (check all that apply) affectionate aggressive  
avoidant fight/argue often follower friendly leader outgoing shy/withdrawn  
submissive other (specify): \_\_\_\_\_  
What do you wish were different about your friendships? \_\_\_\_\_

**SPIRITUAL/RELIGIOUS**

How important to you are spiritual matters? not little moderate much  
Are you affiliated with a spiritual or religious group? \_\_\_\_\_ If yes, what? \_\_\_\_\_  
Were you raised within a spiritual or religious group? \_\_\_\_\_ If yes, what? \_\_\_\_\_  
Would you like your spiritual/religious beliefs incorporated into the counseling? If yes, describe: \_\_\_\_\_

**HEALTH INFORMATION**

Name of your medical doctor: \_\_\_\_\_  
Address of medical group: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of your psychiatrist/prescriber: \_\_\_\_\_  
Address of psychiatrist/prescriber: \_\_\_\_\_ Phone: \_\_\_\_\_  
Have you ever been hospitalized? (If yes, please provide details): \_\_\_\_\_

Are you currently taking any prescribed medications? (Please list names, dosages, frequency, and prescriber): \_\_\_\_\_

Have you experienced any recent healthy or physical changes? \_\_\_\_\_  
Please list any current health concerns: \_\_\_\_\_  
Have you been diagnosed with a learning disability, identified as gifted, other special circumstances? \_\_\_\_\_

Have you previously participated in psychotherapy? \_\_\_\_\_  
Therapist Name \_\_\_\_\_ Location (City/State) \_\_\_\_\_ Dates \_\_\_\_\_

Was it helpful? (Why or why not?) \_\_\_\_\_

Have you ever had thoughts of wanting to end your life? yes no If yes, when? \_\_\_\_\_  
Have you ever had a plan as to how, when, or where you might end your life? yes no If yes, when? \_\_\_\_\_  
Do you have any previous suicide attempts, self destructive behaviors, or violent behaviors? yes no  
When did you have these? (indicate age, circumstances, and whether it led to hospitalization or legal problems) \_\_\_\_\_

Have you ever thought about seriously harming another person? yes no If yes, when? \_\_\_\_\_  
Have you ever attempted to physically harm someone? yes no If yes, when? \_\_\_\_\_

Please list any past drug and alcohol use. What have you used and how much? \_\_\_\_\_

The following has resulted from my use of alcohol/drugs: traffic ticket/violation ruined relationship  
black outs fight with friend problems with school/job difficulties with memory  
What are you currently using and how much? \_\_\_\_\_  
What is the frequency of use? several times per week weekly monthly less than once per month

Have any family members been diagnosed and/or treated for mental or emotional conditions? yes no unsure  
If yes, please explain: \_\_\_\_\_

**OTHER**

What do you consider your main strengths? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What special areas of interest, activities or hobbies do you enjoy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often do you participate in/do the above now vs. in the past? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your primary challenges right now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your most important hopes or dreams? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please add any additional information that may be helpful to our work together. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_