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Client Name:_____ Today's Date:_____

Gender: _____ Age:_____ Date of Birth:_____ Social Security #:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Telephone Numbers:_____ _____ _____
(home) (work) (cell)

May I leave messages for you at home: Yes____ No____

May I leave messages for you on cell: Yes____ No____

On Text: Yes____ No_____

On Email: Yes____ No_____ E-mail address: _____

Parent/Guardian Name: _____

Medical Insurance Information:

Name of Insurance Company:_____

Subscriber Name:_____ Subscriber D.O.B._____

Subscriber I.D. #:_____Group I.D.#_____

Subscriber Employer:_____

Has yearly deductible been met?_____ co-pay amount:_____

If you have additional insurance coverage, please provide the name, ID# and phone number for secondary insurance: _____
_____

Insurance Fees for service are: $250 for an initial assessment, $90 for a 30-minute session, $129 for a 45-minute session, $160 for a 60-minute individual session, $50 for 15 min case management. I understand that I am ultimately responsible for these fees, and agree to pay any balance not covered, or disallowed by insurance. I further understand, and agree that I will be charged 50% for any missed session that I fail to cancel within 24 hours. (Second no show or late cancellation will be charged at 100%) I hereby authorize release of any personal information necessary to process my claim, including my diagnosis. I understand that this information may become a permanent part of my insurance records.

_____
Signature of financially responsible party Date

I have read and I understand the Notice of Privacy Practices that was provided to me.

_____
Signature of client and/or parent/guardian Date

Client Name:_____ **Date:**_____

In order to assist in helping you reach your goals and move forward in the direction you would like to be going in your life, it will be important for me to understand your current difficulties as well as past experiences. Please answer the questions below, noting that the information you provide here is protected as confidential information.

CURRENT FAMILY/LIVING SITUATION

With whom do you currently live? Please list names and relationship to you:

_____
_____
_____
_____
_____
_____

What are your current living arrangements?

- ☐ Living with a parent
- ☐ Living with another relative
- ☐ Living with a friend/roommate
- ☐ Living in a group home
- ☐ Homeless – if yes, where do you stay? _____

Have you been homeless in the past? _____
If yes, please list dates: _____

Are you using any community resources/services currently? If yes, please describe:

_____
_____

PRESENTING PROBLEM

Describe the problem(s) that brought you here today:

_____
_____
_____
_____
_____

Describe an example of the problem, as you see it:

_____
_____
_____
_____

How often does the problem occur? _____

How long does it last? _____

How long has the problem been going on? _____

How serious a problem is this, as far as you are concerned? _____

Who is bothered most by this problem? _____

How have you handled this situation in the past? What strategies have you tried, and how have these worked?

_____
_____
_____

Check any of the symptoms you have been having (continues on next page):

___Depressed mood

___Change in eating habits

___Difficulty with school or work

___Low self-esteem

___Trouble concentrating

___Feeling guilty

___Muscle tension

___Eating problems

___Trouble performing job responsibilities

___Perfectionism

___Problems getting along with family

___Anger outbursts

___Difficulty enjoying usual activities

___Physical complaints of pain

___Problems in relationships

___Weight/appetite changes

___Memory problems

___Problems getting along with others

___Feeling of extreme happiness

___Isolation/withdrawal

___Problems with sleeping

___Feeling fearful

___Tearful/crying spells

___Lack of energy

___Worries

___Feeling stressed

___Feeling hopeless

___Irritability

___Sudden feelings of panic

___Obsessions or compulsions

___**Self harm***

___**Acting violently***

___**Thoughts of killing self***

___**Thoughts of killing others***

___**Legal Issues***

___**Seeing things that others do not***

___**Other***: _____

***Describe in detail:**

_____
_____
_____
_____
_____
_____
_____

PRIOR COUNSELING/MENTAL HEALTH HISTORY:

Please describe any prior counseling below starting with the most recent first.

Therapist name(s):_____
Details:_____
_____
_____
_____
_____

Current and/or prior psychiatric medication history (include doctor's name):

_____
_____
_____

Name of current medications and dosage(s):

_____
_____
_____

Have you ever been hospitalized for a mental health issue, or been admitted to an inpatient psychiatric unit? If yes, please provide reason for admittance, dates of stay, and outcome of treatment:

_____
_____
_____

SUBSTANCE USE HISTORY:

Check if not applicable _____

Alcohol use ___Current ___Suspected ___Past ___No

Recreational drugs ___Current ___Suspected ___Past ___No

List type of drug used_____

MEDICAL HISTORY:

Have you been seen by a doctor within the last year? ___Yes ___No
Purpose of visit: _____
_____

Primary Care Provider:_____Phone:_____

Please list any prescription or over-the-counter medications currently being taken:

_____
_____

Please list any major medical problems such as serious illness, operations, injuries or trauma to the head, etc:

_____
_____
_____

List allergies:

_____
_____

EDUCATION/WORK HISTORY:

Do you attend school? If so, name of school: _____

What year in school are you currently? _____

If not in school, what was your highest grade completed in school? _____

Are you currently employed? _____ If yes, what is your job? _____
_____

Are you having any difficulties with your job? If yes, please describe: _____
_____
_____
_____

Please note any current financial stressors: _____
_____
_____

FAMILY/CHILDHOOD HISTORY - DEVELOPMENTAL INFLUENCES:

I'd like to know more about your history and what impacted you most growing up.

Place of birth? _____ Who has raised you? _____
_____
_____

Have you ever been made to feel ashamed (embarrassed, humiliated)? What happened?

_____
_____

Stressful Events: Please describe any history of parental separation, divorce, moves, major accidents, deaths, traumatic events, abuse (physical, sexual or emotional), etc.

_____
_____
_____
_____
_____
_____

Has anyone in your family ever been treated for a psychiatric disorder or emotional problem? If yes, who, and for what? _____
_____
_____

Has anyone in your family had problems with substance abuse or addictiond? If yes, please describe: _____
_____
_____
_____

SPIRITUAL/PERSONAL INFORMATION:

What do you do for fun? (Hobbies and interests)

_____
_____

Who or what gives meaning to your life now? _____
_____
_____

Do you have any family and/or friends that you can trust and rely on for emotional support?

_____
_____

Are you actively involved in religious or spiritual practices? _____
_____
_____

How do you view your future? _____
_____

What helps you get through difficult situations? _____
_____
_____

What are the top 1-3 things you would like to see change in your life right now?
_____
_____
_____
_____
_____
_____

What are the most important reasons why you want to make the changes above?
_____
_____
_____
_____

What goals would you like to work on in therapy?
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire. I look forward to meeting with you and working with you on your goals!