Client Information - Adult

Client's name: ________________________________ Today's date: ____/____/______

Address: ____
(Street) (City) (State) (Zip)

Date of birth: ___/___/______ Gender: _______________Sexual orientation: _______________

Pronouns you prefer: __________________ Preferred name: ____________________________

Age:________ Occupation: ____________________________ Employer: __________________

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 Preferred number?_______________

Please provide a name and phone number in case of emergency: ___________________________

PAYMENT INFORMATION

Private/Self Pay: ☐Yes ☐No

If you are using insurance (circle one): Health New England or Blue Cross Blue Shield

*__You are ultimately responsible for payment of any charges incurred, regardless of whether your insurance honors this claim. Please call your insurance company before your first appointment to clarify your benefits.__

Signature indicating that you understand and agree to this payment arrangement:_______________

Co-pay or coinsurance (this should be on the front of your card): $______________

Name of Policy Holder: ____

Birth Date of Policy Holder: ____

Address of Policy Holder: ____

Insurance ID Number of Policy Holder: ____

REFERRAL INFORMATION

Current reason(s) for seeking therapy: ____

____

____

Please estimate the degree of difficulty experienced in each area by marking an 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 (please specify):____

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

☐ coping ☐ anxiety ☐ depression ☐ fears/phobias ☐ eating disorder ☐ gender concerns

☐ sleeping problems ☐ addictive behaviors ☐ parenting concerns ☐ work/life balance

☐ spiritual/existential concerns ☐ sexual concerns ☐ stress management

☐ other (please specify): ____

FAMILY INFORMATION

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

Name Age Relationship (i.e., parent, spouse, partner, child, etc.)

____

____

____

Your current relationship status (more than one answer may apply): ☐ partnered (for #____yrs)

☐ same-sex relationship (for #_____yrs) ☐ legally married (for # ____yrs) ☐ single (for #___yrs)

☐ unmarried, living together (for # _____ yrs) ☐ separation in process (length of time: ____yrs)

☐ divorce in process (length of time: ______yrs) ☐ divorced (length of time: _____yrs)

☐ widowed (length of time: _____yrs) total # of marriages: _______

☐ Your assessment of current relationship status: ☐ Good ☐ Fair ☐ Poor ☐ N/A

Have you, or those close to you, experienced any of the following?

	You - Currently	You - Past	Your Partner	Your Parent(s)	Your Sibling(s)	Other
Depression/sadness						
Anxiety/Panic attacks						
Obsessions/compulsions						
Suicidal thoughts						
Attempted suicide						
Gender dysphoria						
ADD/ADHD/ inattention						
Learning disabilities						
Schizophrenia						
Bipolar disorder						
Drug abuse						
Alcohol abuse						
Eating disorder						
Physical abuse						
Sexual abuse						
Self-injury (intentional)						
Hospitalized (psychiatric)						
Other:						

HEALTH INFORMATION

Name of your medical doctor: ____

City and State of medical group:____

Name of psychiatrist/prescriber:_______________________________________

City and State of psychiatrist/prescriber:_____________________________________

Have you ever been hospitalized? (if yes, please provide details):_________________________________

____

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

____

____

Please list any *past* drug or alcohol use/abuse. What substances were used, when, how often?

____

List any substances used *currently*: ____

Frequency of use: ☐daily ☐several times a week ☐weekly ☐monthly ☐less than once per month

Have you previously participated in psychotherapy? ☐Yes ☐No

Therapist name	Location (City/State)	Dates

Was it helpful ☐Yes ☐No Why or why not?____

What do you consider your strengths?____

____

____

What activities or hobbies do you enjoy?____

____

____

What are your primary challenges right now?_______________________________________

____

____

Please add any additional information that may be helpful to our work together:____________

____

____

____

Thank you!

Consent for Psychotherapy and Terms of the Agreement Signature Page

By signing below, the client acknowledges that they have reviewed and fully understand the terms and conditions of this agreement.

The client has discussed the terms and conditions with the therapist and has had the opportunity to have any questions with regard to its terms and conditions answered to client's satisfaction. The client agrees to abide by the terms and conditions of this agreement and consents to participate in psychotherapy with Amy Gray, LICSW.

Moreover, the client agrees to hold Amy Gray, LICSW free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Name of Client (print):____

Signature of Client (if over 18 years of age):____

Date: ________________

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION SIGNATURE PAGE

This form is an agreement between you (the client)______________________________ and Amy Gray, LICSW.

When I assess, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also be required to share this information to arrange payment for your treatment with insurance companies or for other business or government functions**.**

By signing this form you are agreeing that you have read and understand my Notice of Privacy Policies and you are agreeing to allow me to use your information and to send it to others in accordance with our written policies. Please make sure you have read and understand my Privacy Policies before signing this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Policies, I cannot work with you.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that date on.

Name of Client (print):____

Signature of Client (if over 18 years of age):____

Date: ________________