Katherine Turner, LCSW

All information is confidential

Client Information:

Name(s):____

____

Address: Street____
City ___________________________ ST _______ Zip Code _______________

Age(s): _________ Date(s) of Birth: _____/____/____ ____/____/______
Telephone: Home ______________Work ______________
Cell(s) _________________/________________________

Who is the insurance holder? _______________________________
Their date of birth__________
*Address if different than above_____________________________________
Name of Employer____

Is there a phone number I may use when I need to leave a message regarding appointments, medical information etc?
____

In the rare case of an emergency, who should I contact? (not your home number)
Name ______________________________
relationship ____________________Telephone: _______________________

Who referred you to this office?______________________________________

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Katherine Turner, LCSW to provide evaluation and treatment

____
Signature (s) date

____

Mental Health History

Briefly describe the nature of the problem for which you are seeking help:

Please list the mental health professionals you have seen in the past (psychiatrists, psychologists, social workers, therapists, counselors):

Name	Locations	Dates	Reason

Please list any past psychiatric hospitalizations/partial programs you have been admitted:

Hospital	Date	Reason for treatment

List all medications you are currently taking, when you take it and for what reason.

Medication	time of day	Reason for medication

Please list any psychiatric medications you have taken in the past

Medication	Date	Reason for medication

In the space below, please indicate if there are any issues from your childhood or adolescence which you feel may be of significance (e.g. childhood illness, school problems, parents' divorce, family conflict, history of any type of abuse, etc.)

____
____
____
____
____

General Medical History

Please list any current or ongoing medical conditions that you are being treated:
____
____
____
____
____

Do you smoke? ____No ____ Yes, if so, how much per day?
____

Please describe your alcohol use:
Type of alcohol   Amount   How often
____
____
____
____
____

Please list any current or past use of other types of drugs:
Drug   Amount used   How often   Last used
____
____
____
____
____

Have you ever been diagnosed with or treated for a substance use problem?

_____ No _____ Yes   If so, where and when?
____
____
____

Family History

Name Age Psychiatric, substance abuse and medical history

Mother

____

Father

____

_

Siblings____

____

____

____

____

Children:

____

____

____

____

____

Others: (grandparents, cousins etc.)

____

____

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____

____