

Balance Counseling and Wellness

26461 104th Ave SE, Kent, WA 98030
(253) 499-4239 ph;www.experiencebalance.com

INITIAL INTERVIEW FORM

Date _____

Name _____ Age _____ Birthdate _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

How long have you worked there? _____ How long in this career field? _____

Circle one or more: Single Separated Widowed Divorced Married Coupled, Not Married

Others living at home and their ages _____

How did you choose your therapist? _____

Whom may we thank for referring you? _____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION (Please be sure to present insurance card to office staff, if using. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING COPAY AMOUNT AND AUTHORIZATION REQUIREMENTS.**)

PRIMARY INSURANCE

Name _____ Relationship to client _____

Phone (if different from above) _____ Birthdate _____

Address (if different from above) _____

Insurance company (if applicable) _____ Policy/group number _____

Insurance billing address _____

Insured's ID # _____ Insurance company's phone number _____

SECONDARY INSURANCE

Insurance company _____ Policy/group number _____

Insurance billing address _____

Insured's ID # _____ Insurance company's phone number _____

FINANCIAL RESPONSIBILITY

I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES REGARDLESS OF INSURANCE COVERAGE.

X _____
Signature of Responsible Party

PLEASE COMPLETE OTHER SIDE

Please describe any prior therapy you have participated in. Include dates, name(s) of therapist(s) and focus of treatment.

Please describe what you would currently like help with. What do you hope to achieve?

Are you currently being treated for any physical or emotional problems? If so, please describe:

Do you have any chronic medical conditions or disabilities? _____

Do you have any difficulty with your vision or hearing? _____

Have you ever had a head injury or seizure disorder? Yes No Dates _____

Name of physician _____ Date of last physical exam _____

Names of other current healthcare providers and their specialties _____

Are you taking any nutritional or herbal supplements or medications (including over-the-counter medications)? If so, please list names and dosages:

Number of caffeinated beverages consumed per day (coffee, tea, cola, etc.) _____

Do you drink alcohol? Yes No What kind/how much/how often? _____

Do you smoke? Yes No Do you use any other substances (e.g., marijuana, cocaine, etc.)? Yes No

What kind/how much/how often? _____

Do you have any trouble sleeping? Yes No Describe _____

Have you recently gained or lost weight? How much/over how long? _____

Indicate if you are currently experiencing any of the following health conditions:

Abdominal pain	Change in bowel habits	Loss of interest in sex
Shortness of breath	Nausea or vomiting	Problems with sexual function
Chest pain	Ulcers	Change in menstrual pattern
Palpitations (racing heart)	Irritable bowel syndrome	Pregnancy
Hypertension	Colitis	
Chronic pain	Skin problems	TMJ/grinding teeth
Headaches		Loss of tooth enamel
Problems with muscles or joints		

I am (circle): left handed right handed I use: glasses hearing aid other sensory aid