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Contact Information & History

Name_____Date_____

Address_____

Phone: Home_____Work_____Cell_____

Can I leave voice messages? Yes No If Yes, please circle: Home Work Cell

Can I email you? Yes No Email_____

Emergency Contact/Relationship_____

Age_____ Date of Birth_____ Relationship Status_____

Do you have children? Yes No Ages_____

Employment/Student Status_____

Referral source_____

May I thank them? Yes No

Will you be filing insurance? Yes No

Primary insurance carrier_____Phone_____

Policy Holder_____Relationship to policy holder_____

Policy #_____Group #_____

Deductible and amount met_____Copay/Coinsurance amount_____

Benefit period_____Is prior authorization required? Yes No

_____

Have you received previous mental health treatment (therapy and/or medication management)? Yes No

Please list previous mental heath providers and dates:

_____

Please list current mental health providers, dates and contact information:

_____

Are you currently taking any medications? Yes No
Please list all medications and for what purpose:

_____

_____

Have you ever been hospitalized for mental health concerns? Yes No

Please check items of concern from list below:

	Concern regarding another person		Shyness, being assertive
	Schoolwork/Employment		Anxiety, fears, worries
	Procrastination, getting motivated		Irritable, angry, hostility
	Adjustment/life transition		Physical stress
	Test anxiety/speech anxiety		Sleep problems
	Relationship with peers		Eating problems
	Relationship with romantic partner		Alcohol and/or drugs
	Family relationship		Depression
	Grief/loss of significant person		Parental substance use
	Sexual concerns		Religious/Spiritual concerns
	Sexuality concerns		Financial concerns
	Racial identity		Relationship violence
	Physical, sexual, verbal abuse		Trauma
	Self-esteem, self-confidence		Body image concerns
	Loneliness, homesickness		Other:

What efforts have you made to deal with these concerns?

_____
_____
_____

What are some of your desired outcomes for the therapy process?

_____
_____
_____