Balance Counseling and Wellness

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(253) 499-4239 ph; www.experiencebalance.com

INITIAL INTERVIEW FORM

Date_____

Name_____Age_____Birthdate_____

Address_____Apt#___City_____State_____Zip_____

Employer_____Occupation_____SS#_____

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		