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*Your answers to these questions are confidential. Please ask me any questions you may have in filling out the form.*

1. Date: _____ 2. Full Name: _____

3. Date of Birth: _____ 4. Social Security #: _____

5. Occupation: _____

6. Address (Home) – may I send mail to you here? YES NO

Street: _____

City/St/Zip: _____

_____

7. Phone #s – may I leave a message at this #?

Day: _____ YES NO

Eve: _____ YES NO

Cell: _____ YES NO

8. Medical Insurance Co: _____ Subscriber #: _____

Insurance contact person: _____ Insurance Phone #: _____

9. Email Address: _____ May I email you? YES NO

10. Primary Care Physician: _____ Phone: _____

10a. Date of last physical exam: _____

11. Do you currently see a psychiatrist? YES NO

Name: _____ Phone: _____

May I contact your physician(s) if necessary? YES NO

Please provide your signature indicating your consent: _____

12. List any health problems for which you currently receive treatment or have received treatment in the past.

_____

_____

_____

13. List any medications (prescription or non-prescription) you are currently taking.

Type Dose Reason

_____

_____

_____

_____

14. How were you referred to me? _____

15. Previous counseling experience? YES NO

Dates Therapist's Name

_____

_____

_____

_____

16. Please indicate current use and frequency of use of the following substances:

| | More than once a day | Once a day | Every 2-3 days | Weekly | Monthly | Yearly or less | Never |
|---|---|---|---|---|---|---|---|
| **Alcohol** | | | | | | | |
| **Non-prescription Drugs** | | | | | | | |
| **Nicotine** | | | | | | | |
| **Caffeine** | | | | | | | |
| **Prescription Drugs** | | | | | | | |

17. Who else lives in your household? What is their relationship to you?

_____

_____

_____

_____

18. Please state the reason(s) you are seeking therapy.

_____

_____

_____

_____

19. How many sessions do you think it might take to address your concerns? _____

20. Person to contact in case of emergency:

Name: _____ Phone: _____

Relationship: _____

*Thank you!*