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Date: ___________

Name: ________________________________ DOB: _______________ Age: __________

Address: _______________________________ City, Zip: _________________________

Home phone: __________________ Cell: _______________ Email: __________________

What is the best way to contact you? ____

Who should I contact in case of an emergency? ____________________________________

Relationship: _________________________________Number: ______________________

What major changes occurred recently in your life? _________________________________

What ethnicity or cultural background do you identify with? __________________________

Insurance

Plan: ____________________ ID #_____________________ Group # _______________

Relationship to insured: self ○ spouse ○ other ○

Insured's name: ________________________________ Insured's DOB: _______________

Insured's address: _______________________________ City, Zip: ____________________

What brings you to therapy? ____

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Have you been given a diagnosis for this issue? If so, what was the diagnosis and recommended

treatment? ____

Are you taking medication? If yes, what and for what purpose? __________________________

Have you sought previous mental health care from another provider? If yes, from whom and why?

____

What other professionals are you working with? ______________________________________

What are your medical concerns? ____

____

Habits

	Heavy	Moderate	Light	None	Comments
Alcohol					
Caffeine					
Tobacco					
Drugs					
Exercise					
Sleep					
Appetite					
Vitamins					
Stress level					

Do you have a spiritual practice? Please describe briefly: ______________________________

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What would you specifically like to accomplish in therapy? ____________________________

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How did you hear about me? ____