Accepted Therapy Services
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Today's Date: _____

Client Information

Last Name First Middle		Preferred Name		Pronouns
Is this your legal name? * Yes * No	What is your legal name?	Age	Birthday	Sex ( ) M ( ) F
( ) Single ( ) Married ( ) Divorce ( ) Widowed How Long _____ Years				
Address City State Zip			Home Phone:	
Occupation	Employer		Cell Phone:	
Do you like what you do? Explain.			Work Phone:	
			Email Address:	
How did you hear about us? ( ) Referred by: ( ) Internet ( ) Insurance Plan ( ) Family ( ) Friend ( ) Close to home ( ) Other				

Spouse Information

Last Name First Middle			Age	Birthday	Sex ( ) M ( ) F
Address: City State Zip				Occupation:	
Home Phone:	Cell Phone:	Work Phone:		Employer:	

Children's Information

Child's Name	Age	Birthday	Sex ( ) M ( ) F	Lives w/you ( ) Yes ( ) No
Child's Name	Age	Birthday	Sex ( ) M ( ) F	Lives w/you ( ) Yes ( ) No
Child's Name	Age	Birthday	Sex ( ) M ( ) F	Lives w/you ( ) Yes ( ) No
Child's Name	Age	Birthday	Sex ( ) M ( ) F	Lives w/you ( ) Yes ( ) No

Emergency Contact		
Contact Name:	Relationship:	Contact Number:
Contact Name:	Relationship:	Contact Number:
Contact Name:	Relationship:	Contact Number:

Insurance Information			**(copy of insurance card required)**
Responsible Party:	Birthday:	Relationship to client	Home Phone:
Address (if different):			Cell Phone:
Occupation:	Employer:		Work Phone:
Is the client covered by insurance? ( ) Yes ( ) No			Self Pay ( ) Yes ( ) No
Primary Insurance Provider:			
Insured's Name	Birthday	Policy Number	Group Number
Client's relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other			Copay:
Secondary Insurance Provider (if any):			
Insured's Name	Birthday	Policy Number	Group Number
Client's relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other			

Presenting Problem - What brings you here today?

Current Symptoms (Check all that apply)

( ) Anxiety	( ) Appetite Issues	( ) Avoidance
( ) Depression	( ) Excessive Energy	( ) Fatigue
( ) Hallucinations	( ) Impulsivity	( ) Irritability
( ) Lost of interest	( ) Panic Attacks	( ) Racing Thoughts
( ) Sleep Changes	( ) Suspiciousness	( ) Thoughts of Suicide
( ) Crying Spells	( ) Guilt/Shame	( ) Libido Changes
( ) Grief/Loss	( ) Risky Activity	( ) Other: _____

Medical Information

Doctor's Name		Phone:	
Address	City	State	Zip

Medications

Name	Dosage	Frequency	Route
Name	Dosage	Frequency	Route
Name	Dosage	Frequency	Route
Name	Dosage	Frequency	Route

Family History of Mental Health (Please Explain)

Suicidal Ideations

Current Suicidal Ideations ( ) Yes ( ) No Details _____

Current Suicide Plan ( ) Yes ( ) No Details _____

History of Suicidal Ideations ( ) Yes ( ) No Details _____

History of Suicide Attempts ( ) Yes ( ) No Details _____

Substance Use

Do you use nicotine (smoking, vaping, dipping, etc.)? If so, how much/day? _____

How much alcohol do you typically consume per week? Be specific.

Have you ever used any illegal substances or misused a prescription? ( ) Yes ( ) No

Additional Information

Use the space below to list any other information that you feel is important for me to know.

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_____ _____

Signature Date

_____ _____

Clinician Date