

Client Name: _____ Date Completed: _____
Client Age: _____

Reason for Seeking Treatment: _____

Rate Intensity of Presenting Problem: 1 2 3 4 5 6 7 8 9 10

	<u>Yes</u>	<u>No</u>	<u>Explanation:</u>
Normal Energy Level:	_____	_____	_____
Sleep Disturbance:	_____	_____	_____
Appetite Changes:	_____	_____	_____
Exercise:	_____	_____	_____
Anger/Hostility:	_____	_____	_____
Poor Concentration:	_____	_____	_____
Irritability/Agitation:	_____	_____	_____
Mood Swings:	_____	_____	_____
Obsessive Thoughts:	_____	_____	_____
Compulsions:	_____	_____	_____
Anxiety/Tension:	_____	_____	_____
Memory Problems:	_____	_____	_____
Fearfulness:	_____	_____	_____
Hallucinations:	_____	_____	_____
Paranoid Thoughts:	_____	_____	_____
Depressed Mood:	_____	_____	_____
Hopelessness:	_____	_____	_____
Suicidal Thoughts:	_____	_____	_____
Homicidal Thoughts:	_____	_____	_____
Family/Friend Support	_____	_____	_____
Social Isolation:	_____	_____	_____
Violent Behavior:	_____	_____	_____
Arrests:	_____	_____	_____
Legal Issues:	_____	_____	_____
Prior Therapy:	_____	_____	<u>With Whom:</u> _____ _____
			<u>Dates:</u> _____
			<u>Diagnoses:</u> _____
Psychiatric Hospitalization:	_____	_____	<u>Where?</u> _____ <u>When?</u> _____ <u>How Long?</u> _____
Have you ever been on Disability:	_____	_____	_____
Highest Education You've Attained:			_____
Religious/Faith Orientation:			_____

Client Name: _____

Caffeine Use	_____	_____	How Much?	_____
Cigarette Smoker	_____	_____	How Much?	_____
Alcohol	_____	_____	Frequency?	_____
			Amount?	_____
			Last Used?	_____
Drug Use	_____	_____	Type (s):	_____
			Amount?	_____
			Last Used?	_____

Current Mediations:	<u>Name</u>	<u>Dosage</u>	<u>Date Begun</u>	<u>Prescribed By</u>
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

<u>Medical Conditions:</u>	<u>Yes</u>	<u>No</u>	<u>Explanation:</u>
Hepatitis:	_____	_____	_____
Thyroid Disease:	_____	_____	_____
HIV/AIDS:	_____	_____	_____
Diabetes:	_____	_____	_____
Heart Disease:	_____	_____	_____
Gastrointestinal:	_____	_____	_____
Seizures:	_____	_____	_____
Migraines:	_____	_____	_____
Cancer:	_____	_____	_____
Drug Allergies:	_____	_____	<u>List:</u> _____

Other Medical Conditions:	_____	_____	_____
Hospitalizations:	_____	_____	<u>Reason:</u> _____

			<u>When?</u> _____

Family History:

Have members of your family ever had any of the following problems? Include parents, grandparents, uncles, aunts, brothers, sisters, and children.

Depression:	_____	_____	_____
Anxiety:	_____	_____	_____
Manic Depression/Bipolar	_____	_____	_____
Suicide Attempt:	_____	_____	_____
Completed Suicide:	_____	_____	_____
Learning Disability:	_____	_____	_____
Schizophrenia:	_____	_____	_____
Alcohol Abuse:	_____	_____	_____
Drug Abuse:	_____	_____	_____

Client Information Form

Client Name _____ New Client? _____ Client Update? _____
Must be full, legal name of the person being seen for therapy

Address _____
Street or PO Box City State Zip

Social Security Number _____ Date of Birth _____ Gender M F

Home Phone _____ Y N May I leave a message?
Work Phone _____ Y N May I leave a message?
Other Phone _____ Y N May I leave a message?
Please identify

Client Marital Status
Single Married Other

Client Employed?
Yes No

Client Student Status
Full Time Part Time

Email: _____

How Did You Hear About My Practice? **Please be as specific as possible*

Former/Current Client Healthcare Professional Yellow Pages Mental Health Provider
Insurance Company Word of Mouth Internet Other Name _____

Responsible Party Information **The responsible party will receive the bill for any services not covered by insurance. Please only complete information that differs from the client.*

Name _____ Home Phone _____
Address _____ Work Phone _____
Street or PO Box
City _____ State _____ Zip _____ Relationship to Client: _____

Insurance Information **Information in this section should pertain to the Primary Person listed on the insurance card. Please only complete information that differs from the client.*

Insurance Co _____ Insurance Phone# _____
Insured's Name _____ ID# _____ Group# _____
Patient Relationship to Insured Self Spouse Child Other
Insured's Address _____ Home Phone _____
Street or PO Box
City _____ State _____ Zip _____ Insured's SSN _____
Insured's DOB _____ Gender M F Insured's Employer _____

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signature _____ Date _____

Office Use Only Therapist: _____ Diagnosis Code _____

Billing Notes _____