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Welcome to my practice. I look forward to helping you reach your goals. This form requests information about your needs and informs you of my services and policies. Please take a few moments to complete this form, which is confidential under federal HIPAA rules and regulations. The questions on the following pages are designed to help me best meet your treatment needs. If the person seeking care is a child, the parent should complete this form. If you have any questions or concerns, I will be happy to answer them.

Today's Date:_____

Name (Individual or Couple):_____Birthdate(s)_____

Address:_____Age_____

City, State, Zip_____Gender __ Female __ Male __

SSN_____-_____-_____ Relationship status: _____

Home Phone: (____)_____OK to contact there? __ Y __ N

Mobile Phone: (____)_____OK to contact there? __ Y __ N

Work Phone: (____)_____OK to contact there? __ Y __ N

Fax Number: (____)_____OK to contact there? __ Y __ N

Email Address:_____OK to contact there? __ Y __ N

Emergency Contact Name:_____Relationship:_____

Emergency Contact Phone: (____)_____OK to contact there? __ Y __ N

List other persons living in your household and their relationship to you:

Other Household Person's Name:_____Relationship:_____

Other Household Person's Phone: (____)_____OK to contact there? __ Y __ N

Other Household Person's Name:_____Relationship:_____

Other Household Person's Phone: (____)_____OK to contact there? __ Y __ N

Full Time Student? __ Y __ N Occupation:_____ Employed? __ Y __ N

School or Employer Name:_____

Primary Care Physician Name_____

Primary Care Physician Phone and Fax:(____)_____(____)_____

Compsych EAP __ Y __ N Authorization No._____Number of Sessions_____

EAP Consultants __ Y __ N Authorization No._____Number of Sessions_____

BPA EAP __ Y __ N Authorization No._____Number of Sessions_____

Insured Name_____

Insured SSN _____

Insured DOB _____

Employer _____

Health Plan _____

Member # _____

Policy/ Group # _____

Phone #s on back of card _____

Address on back of card _____

Client's relationship to the insured_____

1. Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:

_____

_____

_____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of life:

	No Effect 1	Little Effect 2	Some Effect 3	Much Effect 4	Signifiicant Effect 5	Not Applicable N/A
Relationship						
Family						
Job and/or School performance						
Friendships						
Financial situation						
Physical health						
Anxiety level, Stress, or Nerves						
Depressed Mood						
Manic Mood						
Eating habits						
Sleeping habits						
Sexual functioning						
Alcohol, Drug, other substance usage						
Ability to concentrate						
Ability to control your temper						
Dependence or addiction to_____						
Dependence or addiction to_____						
Dependence or addiction to_____						

2. What result(s) do you expect from treatment?

_____

_____

_____

_____

3. Have you ever received mental health treatment before? If so, please list dates, provider name, the issue for which treatment was sought:

_____

_____

_____

_____

4. Please list any medications and dosages you're currently take:

_____

_____

_____

_____

_____

Client Signature Date