Practical Therapy

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Welcome! In order to get to know you and to better serve you, I need to know some things about you and your life. Please answer each question as completely as you can.

PLEASE BRING YOUR HEALTHCARE CARD AND PHOTO ID TO OUR FIRST SESSION

Date _____ **Referral Source** _____

Client Name: _____

Street Address: _____

City _____State _____ Zip _____EMAIL: _____

Cell Phone ( ) _____Can I leave text messages? YES NO

Work/Home Phone ( )_____

Sex: (circle one) Female Male Age _____ Date of Birth: _____

Your Employer or School:_____

Occupation or Grade/Year of school:_____

Emergency Contact: _____ Phone: _____ Relationship: _____

FAMILY INFORMATION

Partner Status: Single Married Widowed Divorced Separated Other

Partner Name: _____

Father's name: _____ Alive? _____ Age:_____ Occupation _____
Mother's name: _____Alive? _____ Age: _____ Occupation _____
What is/was your parent's marital status?
( ) Married ( ) Divorced ( ) Separated ( ) Father remarried ( ) Mother remarried

First name, age, and sex of any siblings and step siblings you have:

_____

First name, date of birth, and sex of any children you have:

_____

Who do you live with?

_____

INSURANCE INFORMATION:

• Will you be using insurance: YES NO, if yes, please provide name: _____

ID #: _____ Group: _____

Policy holders name (if not your own policy): _____DOB: _____ Relationship:_____

• If you have a Primary and Secondary policy, please provide Secondary information:

Insurance Company: _____

ID#_____Group ID#:_____

Policy Holder Name/Relationship to you: _____

• No insurance and cash pay? YES NO (we will discuss details at our first session)

• No insurance and Using Employee Assistance Benefits (ex.: Ceridian, Compsych, Military One, Optum)

Please provide name of company: _____

Authorization code: _____Number of units/sessions: _____

Please read and sign this.

**Assignment and Release: I the undersigned, certify the I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed a the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions:

_____ _____ _____

Responsible Party Relationship to client Date

EDUCATION

Please indicate your highest education level:

( ) Less than high school ( ) High school equivalent/GED ( ) High school diploma
( ) Vocational ( ) Some college ( ) Bachelor's degree
( ) Master's degree ( ) Doctoral degree ( ) Other: _____

Major/minor/area of concentration

_____

Did you experience any learning problems in school? yes ( ) no ( )
If yes, please describe:

_____

PERSONAL STRENGTHS:

What do you do well and what activities do you enjoy?

_____

What personal qualities would others say you have?

_____

What kinds of support systems (connections) do you have in your life?

_____

LEGAL ISSUES:

Please list any legal issues that are affecting you or your family right now or have had a significant effect on you in the past?

_____

MEDICAL ISSUES/MEDICAL PROFESSIONALS/MEDICATIONS

Medical issues:

_____

_____

Name of prescribing Psychiatrist and/or Primary Care Physician:

_____

Clinic Name:_____

Address _____

Phone Number _____Date of last appointment for meds _____

Name	Dosage	What diagnosis is this treating?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENTAL HEALTH HISTORY

Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no

If yes, please fill in the following information:

Name of professional	Dates of service	Reason
_____	_____	_____
_____	_____	_____

What did you find most helpful in therapy?
_____

What did you find least helpful in therapy?
_____

Have you ever been hospitalized for psychiatric reasons? ( ) yes ( ) no

Is there a history of mental illness in your family? ( ) yes ( ) no

If yes, please explain:_____

SUBSTANCE USE

Please check substances you use on a weekly/monthly basis:

( ) Alcohol _____ x per day/week/month
( ) Marijuana _____ x per day/week/month
( ) Caffeine _____ x per day/week/month
( ) Tobacco _____ x per day/week/month
type: _____

If you have a partner, do you believe your partner's use may be a problem? yes ( ) no ( )
If yes, explain: _____

Have you ever felt you should cut down on your drinking or drug use? YES NO
If yes, explain: _____
Have people annoyed you by criticizing your drinking or drug use? YES NO
If yes, explain: _____
Have you ever felt bad or guilty about your drinking or drug use? YES NO
If yes, explain: _____
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? YES NO
If yes, explain: _____

**previous 4 questions are derived from Cage Source: 1984

PROBLEM SOLVING

What is the main goal or need you have for your first session?

_____

_____

What attempts have you made in the past to deal with these concerns?

_____

_____

THANK YOU FOR TAKING TIME TO COMPLETE THIS FORM.
I LOOK FORWARD TO MEETING WITH YOU.