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 equivalentGED	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.