PERSONAL INFORMATION					
NAME (legal)		PREFERRED NAME	D.O.B.		SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH _ FEMALE _ MALE _ INTERSEX	SEX LISTED WITH HEALTH INSURANCE _ FEMALE _ MALE	WHAT IS YOUR GENDER IDENTITY? _ SAME AS SEX LISTED WITH INSURANCE _ OTHER_________________		PREFERRED PRONOUNS _HE/HIS/HIM __SHE/HER/HERS __THEY/THEM _OTHER____________________________	
PERMANENT STREET ADDRESS:		CITY	STATE	ZIP CODE	COUNTY
HOME PHONE: _________________ CAN WE LEAVE A VOICE MAIL? _ YES _NO	CELL PHONE: ____________ CAN WE LEAVE A VOICE MAIL? _YES _NO CAN WE TEXT TO THIS NUMBER? _YES _NO	EMAIL ADDRESS: ____ CAN WE CONTACT YOU VIA E-MAIL? _YES _NO			
TEMPORARY ADDRESS (IF APPLICABLE)		CITY	STATE	ZIP CODE	COUNTY
MARITAL STATUS _SINGLE _ MARRIED _ DIVORCED _ WIDOWED	CHILDREN / AGES Biological#_________ Age(s)___________ Step#_______________ Age(s) ___________ Adopted#___________ Age(s)	OTHER MEMBERS OF THE HOUSEHOLD (If applicable)			

EMERGENCY CONTACT	
NAME:	EMAIL:
RELATIONSHIP:	PHONE NUMBER:

EMPLOYMENT			
OCCUPATION:	FULL-TIME	PART-TIME	RETIREMENT DATE
EMPLOYER NAME:	RETIRED	STUDENT	

PRIMARY INSURANCE				
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	D.O.B.	EMPLOYER
INSURANCE PROVIDER	SOCIAL SECURITY # OF THE INSURED	POLICY NUMBER		GROUP ID / PLAN NUMBER

COUNSELING INFORMATION
CURRENT THERAPY TREATMENT
REFERRING PHYSICIAN (IF ANY):
HOW DID YOU HEAR ABOUT US?
CHIEF COMPLAINT: What is the reason you are seeking counseling?
HOW LONG HAVE YOU BEEN EXPERIENCING THIS ISSUE?

PREVIOUS TREATMENT

HAVE YOU ENGAGED IN COUNSELING / THERAPY FOR THIS ISSUE PREVIOUSLY? _ YES _NO If YES, please explain

WHEN?____

WHERE / WITH WHOM?____

HAVE YOU EVER ENROLLED INTO A PROGRAM PREVIOUSLY? _ YES _NO If YES, please explain

TYPE OF PROGRAM? __Outpatient Psychotherapy___ Inpatient Psychiatric___Outpatient Substance Abuse___Inpatient Substance Abuse____Self-Help/Peer Group

WHEN?____

WHERE / WITH WHOM?____

GENERAL HEALTH

HAVE YOU BEEN PREVIOUSLY HOSPITALIZED FOR A MENTAL ILLNESS? _YES _NO If YES, please explain

WHEN?____

WHERE?____

FOR WHAT CONDITION?____

HAVE YOU EVER ATTEMPTED SUICIDE? _YES __NO If YES, please explain

____

ARE YOU CURRENTLY HAVING ANY SUICIDAL THOUGHTS? _ YES ___NO If YES, please explain

____

ANY ISSUES WITH MAINTAINING A HEALTHY APPETITE?_ YES _NO If YES, please explain

ANY ISSUES WITH SLEEPING? _YES __NO If YES, please explain

____

SIGNIFICANT HEALTH ISSUES? _YES _NO If YES, please explain

____

CURRENT CONDITION OR POTENTIAL SYMPTOMS WHICH MAY WARRANT FURTHER MEDICAL ATTENTION? _ YES _NO If YES, please explain

____

PHYSICAL HANDICAP? _ YES __NO If YES, please explain

____

MEDICATION

ARE YOU TAKING ANY MEDICATION? __ YES __ NO If YES, please provide details below: PLEASE PROVIDE ATTACHED LIST IF GREATER THAN 5

1) MEDICATION NAME____________ DOSAGE_____________ START DATE ________ END DATE / REFILL DATE_________ DOCTOR____________ LAST SEEN ________

2) MEDICATION NAME____________ DOSAGE_____________ START DATE ________ END DATE / REFILL DATE_________ DOCTOR____________ LAST SEEN ________

3) MEDICATION NAME____________ DOSAGE_____________ START DATE ________ END DATE / REFILL DATE_________ DOCTOR____________ LAST SEEN ________

4) MEDICATION NAME____________ DOSAGE_____________ START DATE ________ END DATE / REFILL DATE_________ DOCTOR____________ LAST SEEN ________

ALCOHOL ABUSE

ALCOHOL INTAKE FREQUENCY? _ NEVER __ DAILY __3-4 TIMES A WEEK _MONTHLY _OCCASIONAL

HAVE YOU NOTICED AN INCREASE IN TOLERANCE? (Please explain)______________________________________

ADDITIONAL DETAILS____

DO YOU HAVE DIFFICULTY STOPPING AFTER FIRST DRINK? _ YES _NO (IF YES, PLEASE EXPLAIN)

ADDITIONAL DETAILS____

TYPE OF ALCOHOL PREFERENCE ? _ N/A _ BEER _MIX DRINKS __HARD LIQUOR _ OTHER (PLEASE SPECIFY)

ADDITIONAL DETAILS____

ALCOHOL CONSUMPTION PER SITTING? _ N/A _ 1-2 DRINKS __3-4 DRINKS __5 OR MORE

ADDITIONAL DETAILS____

ALCOHOL RELATED PROBLEMS? (PLEASE INDICATE AS APPROPRIATE) _ N/A _ FAMILY _ SOCIAL _WORK _ PERSONAL _ SLEEP _
BLACKOUTS / PASSING OUT / SEIZURES _ WITHDRAWALS _COMPLICATIONS WITH MEDICATION

ADDITIONAL DETAILS____

LENGTH OF ALCOHOL RELATED PROBLEMS? _ 1 MONTH OR LESS __6 MONTHS OR LESS _1 YR OR LESS _ LONGER THAN 1 YR _ LONGER THAN 5 YRS

ADDITIONAL DETAILS____

ALCOHOL RELATED TREATMENT ATTEMPTS? _N/A _AA (OR SIMILAR PROGRAM) _OUTPATIENT _ COMMUNITY _SELF

ADDITIONAL DETAILS____

SUBSTANCE ABUSE	AMOUNT	FREQUENCY		
DO YOU USE ANY OF THE FOLLOWING?	VOLUME?	DAILY	WEEKLY	OCCASIONALLY
MARIJUANA				
HEROIN				
COCAINE				
CRACK				
OTHER? (Please explain below)				

OTHER (If applicable)____

ADDITIONAL DETAILS____