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Please note: Information provided here is protected and confidential

Today's date: _____

Name: _____
Date of Birth: _____Age:_____

Address: _____
City: _____State: _____ Zip: _____
Home/Evening phone: _____Work Phone:_____
Cell:_____Email:_____
Calls or e-mail will be discreet, but please indicate any restrictions:
_____

Emergency Information: If an emergency arises, who should be called?
Name: _____ Phone: _____ Relationship: _____

How were you referred to this office?
Name:_____
Internet: _____ Other: _____

May I have permission to thank this person for the referral? ❑ Yes ❑ No

CHIEF CONCERN: Please describe the main difficulty that has brought you to see me:
_____
_____
_____

Religious affiliation (Optional): ❑ Protestant ❑ Catholic ❑ Jewish ❑ Other

Ethnicity/National Origin:
_____

MEDICAL CARE: How would you rate your current physical health?
_____

Doctor's name: _____ Phone: _____

Please discuss your medical history and any medical concerns:
_____
_____

Current Medications and Reason for Use:
_____
_____
_____
_____

Please list any specific sleep problems you are currently experiencing:
_____
_____

Are you currently experiencing any chronic pain? ❑ Yes ❑ No
If you are taking any medications to relieve this pain, please list:
_____
_____

Have you ever received psychological or counseling services, psychiatric evaluation
hospitalizations or drug or alcohol treatment before? ❑ Yes ❑ No
If Yes, please describe:
_____
_____

Please give name of therapist(s), dates seen, reason for treatment:
_____
_____
_____

Did you consider previous therapy to be helpful? Please describe:
_____
_____
_____

Have you ever taken meds for psychiatric or emotional problems? ❑ Yes ❑ No (If yes, please list who prescribed, your understanding of why medication was prescribed, and with what results.)

_____
_____
_____
_____

YOUR CURRENT EMPLOYER:
Name:

_____

Address:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____
_____
_____
_____

YOUR EMPLOYMENT HISTORY:

Previous Employer Name	Dates of Employment	Job Title or Duties	Reason for Leaving

YOUR EDUCATION AND TRAINING:

School	School Name	Dates of Attendance	Did you graduate?
High School:			
College:			
Graduate School:			
Other:			

FAMILY OF ORIGIN HISTORY:

Relative	Living or Deceased?	Current Age (or age at death)	Any Illnesses?	Education/Occupation
Father				
Mother				
Sibling(s)				
Grandparents				

Relationships in your family of origin: Please describe the following:

Your parents' relationship with each other:

_____
_____
_____

Your relationship with each parent and with any other adult present in your home growing up:

_____
_____
_____

Your relationship with your sibling(s), in the past and present:

_____
_____
_____

Please circle if there is a family history of any of the following. If yes, please indicate the family member's relationship to you.

Anxiety	**Depression**
Domestic Violence	**Eating Disorders**
Obesity	**Obsessive Compulsive Behavior**
Bipolar Disorder	**Attention Deficit Disorder (ADD)**
Schizophrenia	**Suicide Attempts**

MARITAL/RELATIONSHIP HISTORY:

Are you in a romantic relationship? ❑ Yes ❑ No. If yes, for how long? _____
How would you rate this relationship?
_____

If married, spouse's name and age:
_____
How well do you get along with your present spouse or partner?
_____
_____

Do you confide in your mate? All the time Sometimes Rarely Never

Is there anything about the affection/intimacy part of your relationship that disappoints you. (Please explain.)

_____

How often do you discuss or have you considered divorce, separation, or terminatin your relationship? All the time Occasionally Rarely Never

Have you been married previously? Please provide dates of these relationships:
_____
_____
_____

YOUR CHILDREN: (Please indicate from which marriage or relationship)

Name	Age	Grade / Occupation

How well do you get along with your children?

_____
_____

Please describe any significant non-marital relationships:

_____
_____
_____
_____
_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Please circle.

Frequent crying spells
Difficulty concentrating
Significant weight gain or weight loss
Loss of interest in daily activities
Difficult making or keeping friends
Mood swings
Feelings of guilt / worthlessness
Suicidal thoughts / suicide attempts
Feelings of fatigue
Sexual difficulties
Aggressive behaviors/Anger outbursts

Are you currently feeling overwhelming sadness, grief or depression? ❑ Yes ❑ No
If yes, for how long?_____

Are you currently experiencing anxiety, panic attacks or any phobias? ❑ Yes ❑ No
If yes, please describe:_____

HISTORY OF TRAUMA:
Abuse history: ❑ I was not abused in any way. ❑ I was abused.
Please share anything additional you think would be helpful for me to know:

_____
_____

YOUR HISTORY OF SUBSTANCE ABUSE: How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

How much beer, wine or hard liquor do you consume each day, on the average? _____ Per week:_____

Which drugs (non-prescription) have you used in the last ten years?

_____
_____

Please provide details about your use of these substances, such as amounts, how often you used them, their effects, etc.:

_____
_____

How much tobacco do you smoke or chew each day/week_____

FAMILY HISTORY OF SUBSTANCE ABUSE:
Relative:_____Substance:_____
Relative:_____Substance:_____

FINANCIAL AND/OR LEGAL DIFFICULTIES: Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No.
If yes, please explain:

_____
_____

Other legal/financial issues causing stress:

_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____
_____

What do you consider to be some of your weaknesses?

_____
_____
_____
_____

Please discuss what you are hoping to accomplish in therapy:

_____
_____
_____
_____

Office Policies and Procedures:

In an effort to establish a trusting therapeutic relationship, I have found that an understanding of my policies prior to your first session should provide answers to many of your questions. Please feel free to ask any further questions that you may have about therapy.

The therapeutic relationship is confidential and very important to me. Written records and/or verbal information cannot be shared with another party without your permission in writing.

The State of Florida also protects your rights to have our conversations considered privileged. However, there are certain mandated legal limitations to confidentiality

1. If I believe that you pose a threat to your life or the life of another person, I am legally responsible to take appropriate measures to prevent such action. This may include contacting appropriate authorities.

2. Abuse of Children and Vulnerable Adults:
If a client states or suggests that he or she is abusing a child under age eighteen or vulnerable adult or has recently abused a minor child or vulnerable adult, or it is reported that a child or vulnerable adult is in danger of abuse, the mental health professional is required by law to report this information to the appropriate social service and/or legal authorities. Once the initial report is filed, I may be required to provide additional information. I will limit my disclosure to what is necessary.

If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action.

Additional Information:

1. Therapy sessions are 50 minutes in length. Longer sessions may be scheduled at your request.

2. Payment is expected at the time of the session. The charge for each session will b due at the beginning of each appointment. Payment can be made by personal chec or cash.

3. I will be happy to provide the necessary form for you to submit to your insurance carrier for reimbursement. Most health insurance policies will reimburse clients fo our services, but some do not.

Please take the time to contact a representative from your insurance company to determine the specific coverage of your policy. Policies may vary about reimbursement for deductibles, percentage of reimbursement, and/or whether an authorization is needed prior to treatment. It is the client's responsibility to evaluate all of this information, and to notify the therapist of any treatment constraints.

4. I am also available for brief phone calls in between sessions. However, in the cas of a true emergency, please contact 911 or proceed immediately to a hospital emergency room.
If there is the need for lengthy phone calls and/or reports, it may be necessary to bi at the regular therapy rate.

5. Cancellation Policy: Please be advised that if you fail to cancel a scheduled appointment in advance, I will be unable to offer this time to another client. There will not be a charge for appointments canceled at least 24 hours in advance. However, if you cancel the same day or fail to keep a scheduled appointment, you will be expected to pay for the missed session.

Your signature below indicates that you have read and understand this agreement and agree to its terms. (Parent or guardian must sign for clients under eighteen.)

DATE: _____Client or Legal Guardian: _____