As we begin our working relationship, I would like to ask you to fill out the following form. To protect your confidentiality, none of this information will be disclosed and nobody will be contacted without your written permission.

Name: _____

Address: _____

City: _____ *Zip Code:* _____

Home Phone: _____ *Work Phone:* _____

Cell Phone: _____ *May we leave a text message?* ____*Yes* ____ *No*

May we leave a voice message? ____*Yes* ___*No* *If needed please specify*_____

Email (list only if you are comfortable to receive occasional email messages)

_____

Birth Date: _____ /_____ /_____ *Age:* _____ *Gender:* _____

Place of Employment: _____ *Occupation:* _____

Marital Status (please circle)

Single, Domestic Partnership, Married, Separated, Divorced, Widowed

Please list any children/age: _____

Spouse/Partner's Name: _____

Emergency Contact: _____

Address: _____

Phone: _____ *Relationship:* _____

Who referred you to our agency? _____

Please list the Name, Address and Telephone number of your Primary Care

*Physican*_____

Insured's Gender: _____ *Date of Birth (insured):* ___ /___ /___

Name of Insured: _____ *Employer:* _____

Insurance Company: _____ *ID #:* _____ *Group #:* _____

Secondary Insurance Company: _____ *ID#:* _____ *Group #:* _____

ADDITIONAL INFORMATION

In the last year have you had a physical exam? ____Yes ____ No

Have you previously received any type of mental health services (e.g., psychotherapy, psychiatric services, etc.)?

____ No

____ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication(s)? ____Yes ____ No

Please list name and dosage: _____

Have you ever been prescribed psychiatric medication? ____ Yes ____ No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. How would you rate your current sleep habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. How many times per week do you exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

_____