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New Client Information

Please answer the following questions to the best of your ability. If you have questions about how to answer any of them, please let me know and we can discuss them in our session.

Date: ______________________________

Last Name: ____ **First Name:** ______________________ **MI:** ____

Age: ________ **Date of Birth:** ______________________

Gender/Gender Preference/Pronouns/ How would you like to be addressed? _____________________________

Street Address: ____

City: ____ **State:**_____ **Zip Code:** ____________________

Home Phone: __________________________________ **Okay to leave message?** ____________

Work Phone: __________________________________ **Okay to leave message?** ____________

Cell Phone: _______________________________ **Okay to leave message?** ____________

Email: _______________________________ **Okay to email?** ___________

Employer: ____

Do you have health insurance? Yes___No____

Insurance Company ____

ID # ______________________________________**Group #**__________________________________

Phone/Fax Number ____

Have you met your yearly deductable? Yes___No____

Do you have a copay or coinsurance? Yes___ No ___ If yes how much? $____________/per session

Do you know if you have out-of-network benefits? Yes ___No____

New Client Information 2

Name of Emergency Contact/Relationship to you: ____

Emergency contact information:

____

Referral Source (how did you hear about me):____

Have you ever been in therapy or counseling before? Yes____ No ____

If so, did you find it helpful? Yes____ No ____

Comments if any about prior therapy____

____

Have you ever been hospitalized for mental health treatment? Yes____No____

If yes, when and where? ____

____

Are you currently under the care of another mental health provider? (e.g. psychiatrist, nurse practitioner?)

Yes ____No _____

Provider Name and contact: ____

____

Are you currently taking any psychotropic medications (e.g. antidepressants, mood stabilizers, medications for anxiety)? Yes __________No___________

If so which ones?____

____

Name and contact information of provider who prescribes the above medications:

____

Signature of person completing this form____

I prefer to use email only for the purposes of scheduling or modifying appointments. Please be aware that email is not confidential. If you choose to communicate information via email or text message that could identify you as a patient, please be aware that you are consenting to the associated privacy risks. Email is not a secure medium and I cannot guarantee that information transmitted will remain confidential.

This form will be retained in your medical record