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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