

## ***Personal Health Information***

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_  
Widowed \_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Please tell me in a sentence how you see the problem that brings you to see me? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did symptoms first appear?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals in therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the past year, have you ever used drugs or alcohol more than you meant to?

Yes \_\_\_ No \_\_\_

Would anyone close to you say that drugs/alcohol are any part of the problem?

Yes \_\_\_ No \_\_\_

Have you had counseling in the past? Yes \_\_\_ NO \_\_\_ Was it helpful? \_\_\_\_\_

If yes:

Dates of Tx?	Name of practitioner?	For?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any medications? Yes \_\_\_ NO \_\_\_ If yes, please indicate:

Medication.	Dosage	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

Do you have notable medical problems that are effecting your functioning, or that might be effected by our work together? Yes \_\_\_ No \_\_\_ If yes, please explain. \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Family and Family of origin Information:

Name	Age (or deceased).	Occupation
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Spouse/Partner	_____	_____
Child	_____	_____
Child	_____	_____

**Payment Information:**

Payment Source: Self Pay \_\_\_\_\_ Insurance \_\_\_\_\_ EAP \_\_\_\_\_

**Employee Assistance Company/ EAP**

If EAP, Name of EAP company \_\_\_\_\_

If EAP, # of sessions \_\_\_\_\_ Authorization # \_\_\_\_\_

Phone number of EAP \_\_\_\_\_

Also, scan and email any form you receive from your EAP, to me with Filing Instructions for their particular EAP company.

**Insurance Company**

Insurance Company Name: \_\_\_\_\_

Name of Plan: \_\_\_\_\_

Insured's ID # \_\_\_\_\_

Insurance Group # \_\_\_\_\_

Employer of Insured (If not you) \_\_\_\_\_

Name of Insured (If not you) \_\_\_\_\_

DOB of Insured (If not you) \_\_\_\_\_

Home Address of Insured with city and zip (If not you)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I am an out-of-network provider, please plan to pay for your sessions at the time of service and have any reimbursements sent to you.