NEW CLIENT INFORMATION

Name _____ DOB ___/___/____ Age _____

Preferred Phone _____ _ □CellPh □HmPh □WkPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □WkPh □Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip _____

May I send mail to this address? Yes No

Email _____May I use email to confirm appointments? Yes No

Employer _____ Type of Work _____

Relationship Status (required by insurance companies)

Single /Married /Partnership /Divorced /Separated /Widowed /Other

Emergency Contact _____Relationship_____Phone_____

Financial Responsibility—*If you will be using insurance benefits, please complete this section:*

Name of Insured _____

Preferred Phone _____ _ □CellPh □HmPh □WkPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □WkPh □Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address _____ City _____ Zip _____

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician as needed to fulfill insurance requirements for processing my claims or as needed for treatment planning and management required by my insurance carrier. I further authorize payment of insurance benefits for services rendered to Paul Abodeely, LMFT.

Financial Responsibility: I understand that if my insurance company should deny payment for any reason, I will be responsible for any outstanding financial debt associated with therapy services.

Client _____ Date _____

Therapist _____ Date _____

What prompted you to seek therapy?

_____

_____

_____

_____

Who is impacted by the issue?

_____

_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____

_____

_____

Have you had any prior counseling or psychiatric treatment? ____ No ___Yes If yes:

When? _____Where? _____

Reason for and length of counseling_____

Check one: Therapy was ____ helpful ___ not helpful. Please explain:

_____

MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician:

_____

Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain:

_____

_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears

____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse? __Yes __No

Have you ever felt like you should cut down on alcohol or other drug use? __Yes __No

Has a friend or relative ever discussed concerns about your drug use? __Yes __ No

Is there a history of problem with alcohol or drug use in your family? __Yes __ No

Have you received help for drug or alcohol dependency? ____ No ___Yes If yes:

1. When? _____ Where?_____

Check one: Treatment was ____ helpful ___ not helpful. Please explain:

_____

MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____