Confidential Patient Information

DRIVER'S LICENSE # _____

HEALTH INSURANCE – POLICY #, GROUP #, ID #, CARRIER NAME

_____

(Important: Please list all Health Insurance companies you may have for coverage)

Name (Legal Name): _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Please list any children/age: _____

Address: _____/_____/_____/_____
(Street and Number) (City) (State) (Zip)

Home Phone: (_____)_____-_____ May we leave a message? ☐ Yes ☐ No

Mobile/Other Phone: (_____)_____-_____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Name & Phone): _____

Referred by (if any): _____

Medicaid (OHP) only – Annual Household Income: $_____ Other Insurance: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No
☐ Yes If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
☐ No
☐ Yes If yes, please list: _____

Have you ever been prescribed psychiatric medication?
☐ No
☐ Yes If yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

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

What types of exercise/activities do you participate in?_____

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

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
☐ No
☐ Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
☐ No
☐ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
☐ No
☐ Yes If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship?
☐ No
☐ Yes If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

☐ Alcohol/Substance Abuse		☐ Eating Disorders	
☐ Anxiety		☐ Obesity	
☐ Depression		☐ Obsessive Compulsive Behavior	
☐ Domestic Violence		☐ Suicide Attempts	
☐ Schizophrenia		☐ Other:	

ADDITIONAL INFORMATION:

1. Are you currently employed?
☐ No
☐ Yes If yes, what is your current employment situation: _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious?
☐ No
☐ Yes If yes, describe your faith or belief: _____

_____

3. What do you consider to be some of your strengths? _____

_____

_____

4. What do you consider to be some of your weaknesses?
_____

_____

_____

5. What would you like to accomplish with your time in therapy? _____

_____

_____

I hereby authorize the use of my signature below on all insurance submissions, and also certify that all information given to this office and/or provider is correct and complete. I hereby authorize this office and/or provider to release all information and/or PHI (Protected Health Information) necessary to process any and all claims and for any purpose necessary to provide counseling/psychotherapy services to me. I hereby authorize payment directly to Attentive Counseling, LLC of any benefits due for counseling/psychotherapy services. I understand that services not covered by insurance are my financial responsibility to Attentive Counseling, LLC. Further, my signature indicates consent and my desire to enter into counseling/psychotherapy with Attentive Counseling, LLC.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____