Client Information

Client Name:

____

Date of Birth: ______ /_______ /_________ Sex: M/F/Other__________ Age: ______

Street:___________________________City:________________State:_____ Zip: ____________

Phone: _____________________________ Texting OK? Yes No

Email:____

(If client is a minor, please fill in parent information for below)

Parent Name ___________________________________	Parent Name _______________________________________
Address: _____________________________	Address: _______________________________
_________________________________ City State Zip	_________________________________ City State Zip
Email: ______________________________	Email:__________________________________
Primary Phone: _______________________	Primary Phone: __________________________
Texting OK? Yes No	Texting OK? Yes No

Party Responsible for billing (if applicable):

Name: _______________________________________ Relationship to client: ______________

I understand that the client is responsible for all amounts due (co-insurance, co-pay, etc.) at the time of service. GM Counseling will file insurance on your behalf.

Marital Status: ▫ Never Married ▫ Partnered ▫ Married ▫ Separated ▫ Divorced ▫ Widowed

Have you ever been previously married? ▫ Yes ▫ No

Number of Children: __________ Ages of children:____________________________________

Are you currently receiving therapeutic services, professional counseling or psychotherapy elsewhere? ▫ Yes ▫ No

Have you had previous psychotherapy?
▫No ▫Yes, at Previous therapist's name ____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

▫Yes ▫No If Yes, please list: ____

If no, have you been previously prescribed psychiatric medication?

▫Yes ▫No If Yes, please list: ____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present?
   (please circle) Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

3. Are you having any problems with your sleep habits? ▫ No ▫ Yes
   If yes, check where applicable:
▫ Sleeping too little ▫ Sleeping too much ▫ Poor quality sleep ▫ Disturbing dreams ▫ Other

4. How many times per week do you exercise? __________
   Approximately how long each time? __________

5. Are you having any difficulty with appetite or eating habits? ▫ No ▫ Yes
If yes, check where applicable: ▫ Eating less ▫ Eating more ▫ Binging ▫ Restricting

Have you experienced significant weight change in the last 2 months? ▫ No ▫ Yes

6. Do you regularly use alcohol? ▫ No ▫ Yes

7. How often do you engage in recreational drug use?
▫ Daily ▫ Weekly ▫ Monthly ▫ Rarely ▫ Never

8. Have you had suicidal thoughts recently? ▫ Frequently ▫ Sometimes ▫ Rarely ▫ Never
Have you had them in the past? ▫ Frequently ▫ Sometimes ▫ Rarely ▫ Never

9. Are you currently in a romantic relationship? ▫ No ▫ Yes
If yes, how long have you been in this relationship? ___________________
On a scale of 1-10, how would you rate the quality of your current relationship? _______

10. In the last year, have you experienced any significant life changes or stressors?

____

11. Have you ever experienced any abuse? ▫ physical ▫emotional ▫sexual ▫ None
If yes, is the abuse currently ongoing? ▫ No ▫ Yes
What is your relationship with the abuser? __________________________________
Are you currently in contact with this person? ▫ No ▫ Yes
When did the abuse occur? (date) ____

12. Have you ever experienced the loss of a close family member or friend? ▫ No ▫ Yes
If yes, who? _________________________________
Date: _____________________________________

Have you ever experienced:
Extreme depressed mood: ▫ No ▫ Yes
Wild Mood Swings: ▫ No ▫ Yes
Rapid Speech: ▫ No ▫ Yes
Extreme Anxiety: ▫ No ▫ Yes
Panic Attacks: ▫ No ▫ Yes
Phobias: ▫ No ▫ Yes
Sleep Disturbances: ▫ No ▫ Yes
Hallucinations: ▫ No ▫ Yes
Unexplained losses of time: ▫ No ▫ Yes
Unexplained memory lapses: ▫ No ▫ Yes
Alcohol/Substance Abuse: ▫ No ▫ Yes
Frequent Body Complaints: ▫ No ▫ Yes
Eating Disorder: ▫ No ▫ Yes
Body Image Problems: ▫ No ▫ Yes
Repetitive Thoughts (e.g., Obsessions) : ▫ No ▫ Yes
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) : ▫ No ▫ Yes
Homicidal Thoughts: ▫ No ▫ Yes
Suicide Attempt: ▫ No ▫ Yes
If yes, when?____

OCCUPATIONAL INFORMATION:

Are you currently employed? ▫ No ▫ Yes

If yes, who is your current employer/position? ___________________________________

If yes, are you happy at your current position? ___________________________________

Please list any work-related stressors, if any: ___________________________________

EDUCATIONAL INFORMATION

Highest degree earned?

▫ High School Diploma ▫ Bachelor's Degree ▫ Master's Degree ▫ PhD

Degree in: ____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious and/or spiritual (circle one or both)
If yes, what is your faith? ____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty | Family Member
Depression: ▫ No ▫ Yes ____
Bipolar Disorder: ▫ No ▫ Yes _____________________________________
Anxiety Disorders: ▫ No ▫ Yes ____
Panic Attacks: ▫ No ▫ Yes ____
Schizophrenia: ▫ No ▫ Yes ____
Eating Disorders: ▫ No ▫ Yes ____
Trauma History: ▫ No ▫ Yes ____
Suicide Attempts: ▫ No ▫ Yes ____
Learning Disabilities: ▫ No ▫ Yes _________________________________
Alcohol/Substance Abuse: ▫ No ▫ Yes ___________________________________

OTHER INFORMATION:

What do you like most about yourself?

What are effective coping/self-regulating strategies that you have learned?

What are your reasons for seeking therapy?

What are your goals for therapy?

Any additional information that would be helpful?

CANCELLATION POLICY

$75 Late Cancellation Fee for cancellations within 24 hours.
For more information please read the Cancellation Policy in the Informed Consent packet and/or website.

I, the undersigned, have read the cancellation policy in the informed consent packet and do agree to the above fee and billing policies of this office.

____

Signature (Responsible Party)   Date

Credit Card Information

Card Holder Name____

Card Number____

Exp. ____________ CVV__________ Billing Zip Code _________________

Insurance Information

Please call your provider beforehand to understand your financial responsibility

I currently accept BCBS, Aetna, Superior/Ambetter, Cigna, Lyra, TriCare & United

Provider____

Member Name_______________________________________

Date of Birth____

Member ID____

Group Number_______________________________________

Please ask before signing below if you have any questions about psychotherapy or office policies. Your signature indicates that you have read the following policies and procedures and agree to enter therapy under these conditions. Your signature indicates you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

- Informed Consent for Psychotherapy
- Confidentiality
- Release of Information
- Appointments
- Fees & Insurance
- Incapacity of Death
- Upheal Services
- Availability
- Social Networking
- Minors
- Risks & Benefits
- HIPPA/HITECH & Notice of Privacy Practice Acknowledgement
- Litigation
- Sobriety Policy
- Teletherapy Services
- Cancellation Policy
- Communication Policy
- Complaint Process

I have read and agree to the terms outlined in the completed paperwork packet of policies and procedures, provided electronically or in paper form.

______________________________ ______________

Printed Client's Name(s) ***Date***

______________________________ ______________

Signature of Client or Legal Guardian if under 18 ***Date***