

Primary Insurance Information:

Name of Insurance Holder (Insured): _____

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Health Plan: _____

Client's Relationship to the Insured: _____

Member number: _____ Policy/ Group number: _____

Insurance Co. Contact Phone Number: _____

Insurance Co. Address: _____

Secondary Insurance Information:

Name of Insurance Holder (Insured): _____

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Health Plan: _____

Client's Relationship to the Insured: _____

Member number: _____ Policy/ Group number: _____

Insurance Co. Contact Phone Number: _____

Insurance Co. Address: _____

******Please bring a copy of your insurance card and driver's license to the first session.******

Family Information:

Marital Status: Married Divorced Separated Single

Spouse/ Partner’s Name: _____ Age: _____

Previous Marriages: _____

Children (Include all biological, adopted, foster, and step):

Name	Sex	Age	Type (B,A,F, S)	Custody Y/N	Lives with
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History:

Father
Name: _____ Rate Relationship (1 poor to 5 great) _____

Mother
Name: _____ Rate Relationship (1 poor to 5 great) _____

Step parents
Name: _____ Rate Relationship (1 poor to 5 great) _____

Do you have any brothers and sisters (including step, foster, and adopted)? _____
If yes how many and birth order:

Any family history of psychological, Emotional, Serious Medical Illness, or Substance abuse issues:

Medical History:

Do you have a primary care physician? Yes No
Name: _____ Phone number: _____

Are you presently under a physician's care? Yes No
If yes, What for?

Do you see any other healthcare providers?
Chiropractor Naturopathic Doctor Acupuncture
Bio-feed back Massage Therapy Other _____

Do you have any allergies? _____

Prescription medications currently taking (include name, dosage, and frequency)

Any over the counter medication, vitamins, sleep aids, other supplements

Lifestyle/ Habits:

Habits	Times per week	Most Ever Used	Current or past
Caffeine coffee/ soda			
Cigarettes, cigars, pipes			
Prescription Medication			

Substance Use/ Abuse History:

Have you ever used drugs or alcohol? Yes No
If yes please describe:

Substance	Amount	Frequency	Last use

Name: _____

Problem Check List (Check all that apply)

Issue	Past Problem	Present Problem
Physical Problem (_____)		
Substance Use (_____)		
Irregular Eating		
Sleep problems		
Performance at School		
Performance at Work		
Performance at Home		
Difficulty Making Friends		
Difficulty Understand Others		
Shyness		
Feeling Victimized		
Feeling Rejected		
Unable to Have a Good Time		
Feeling cut off from others		
Communication Problems		
Sexual Problems		
Financial Problems		
Fear of: (_____)		
Can't Stop Thinking about : (_____)		
Feel Depressed		
Feel Inferior		
Feel Emotionally Numb		
Lack of Confidence		
Excessive Worrying		
Can't Make Decisions		
Low Energy		
Forgetfulness		
Lack of Goals		
Unable to Cope with Day to Day Life		
Afraid of Being on My Own		
Suicidal Thoughts		
Feeling Tense		
Feeling Anxious		
Feeling Angry		
Physical Aggression/Violence		
Can't Sit Still		
Overly Ambitious		
Unable to Relax		
Seeing or Hearing Things Others Do Not		
Nightmares		

Issue	Past Problem	Present Problem
Affairs (emotional, sexual)		
Addiction: substance, food, sex, shopping, gambling		
Issues related to a loss		
Loneliness		
Problems Coping		
Legal problems		
Marriage Issues		
Relationship Issues		
Family Conflict		
Behavioral Problems		
Loss of Interest or Pleasure		
Difficulty Focusing		
Poor Concentration		
Hopelessness		
Worthlessness		
Persistent Guilt		
Irritability		
Change in appetite or weight		
Mood Swings		
Nervousness		
Panic Attacks		
Social Anxiety		
Obsessive Thoughts		
Racing Thoughts		
Compulsive Behaviors		
Easily Distracted		
Impulsive Decision/Behaviors		
Impatience		
Difficulty Finishing Projects		
Low Self-Esteem		
Difficulty saying No		
Fear of Rejection		
Separation/ Divorce		
Anger Issues/ Temper		
Hurting Others		
Hurting Self		
High Risk Behaviors		
Other:		

