Client Information – Adult

Client Name: _____ Birth Name: _____

Date of Birth: _____ Referral source: _____ Social Security Number: _____

Gender: _____ Ethnicity: _____ Highest level of education completed: _____

Home phone: _____ Work phone: _____
OK to leave message? ___yes ___no OK to leave message? ___yes ___no txting ok? ___yes ____no

Mailing Address: _____

City/State/Zip: _____

Emergency Contact: _____
Name Phone

Source of Income: _____ Occupation: _____ Employer: _____

Relationship status: single/never married partnered married divorced separated widowed
Rate your relationship on a scale of 1-10: ____
Living Situation: alone spouse/partner parents roommate(s) children

Name, age, and relationship of others in the home: _____

_____

Previous Mental Health Services? □ No □ Yes, previous therapist/practitioner: _____

Primary Care Provider: _____ Phone: _____

Last Physical Exam: _____ Last Dental Exam: _____

Medical History (please circle):				
High blood pressure	STD	Heart problems	HEP/Liver	
Sleep problems	Surgeries	Loss of consciousness	TB	Urinary problems	Diabetes
Skin problems	Asthma	Appetite/Weight change	W/drawal seizures	Thyroid problems	Pregnancy
Vision problems	Drug reactions	Head injury	Seizures	Kidney disease	Prosthesis
Hearing problems	Allergies _____		Other Diagnosis: _____		

Substance Use: please circle (present = in the past 2 weeks):

	Present		Past			Present		Past			Present		Past			Present		Past	
Tobacco	Y	N	Y	N	Alcohol	Y	N	Y	N	Cocaine	Y	N	Y	N	Marijuana	Y	N	Y	N
Caffeine	Y	N	Y	N	Amphetamines	Y	N	Y	N	Hallucinogens	Y	N	Y	N	Sedatives	Y	N	Y	N
										PCP	Y	N	Y	N	Opiates	Y	N	Y	N

Current Medications (Prescribed & Over the Counter)	Dosage/frequency	Prescribed by	Date 1ST prescribed	Last dose
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY MENTAL HEALTH HISTORY: Please circle yes or no and list the relationship to you.

	Please Circle	List Family Member		Please Circle	List family Member
Alcohol/Sub Abuse	yes/no		Obesity	yes/no	
Anxiety	yes/no		Obsessive Compulsive Behavior	yes/no	
Depression	yes/no		Schizophrenia	yes/no	
Domestic Violence	yes/no		Suicide Attempts	yes/no	
Eating Disorders	yes/no				

In the past 3 months have you experienced significant symptoms of (please circle all that apply):

Aggression	Chronic pain	Fear	Irritability	Self-destructive relationships
Anger	Crying	Flashbacks	Memory problems	Self harm behaviors
	Denial	Guilt		Last suicide attempt_____
Anxiety	Depression		Nightmares	Sexual acting out
Apathy	Difficulty concentrating	Harm or threat to others	Obsessive behavior	Somatic (body) complaints
Avoidance	Disordered eating patterns	Hyperactivity	Panic	Substance abuse
Behavior problems	Dissociation	Hyperarousal (↓pain tol, startle response)	Phobias	Recent loss: _____
Compulsive behavior	Emotional numbing	Insomnia/sleep problems	Self-blame	Other:_____

THIRD PARTY BILLING INFORMATION

Provider:_____ Phone:_____

Relationship:_____

Mailing address:_____

Fee Agreement: $130 intake session, $110/ for 50 min. session

Authorized Signature: I authorize the release of any medical or other information necessary to process appropriate insurance/billing claims. I authorize payment of mental health benefits to Kristin Palmer, MFT. I understand that I am ultimately responsible for payment of services should my insurance company deny payment at any time. I agree to immediately notify my therapist of any changes in my insurance coverage.

Signed: _____ Date: _____