New Client Personal and Mental Health Information

Section 1: Office Information

Today's Date: ____

Full Name :____

Birth Date:____/_____/_____ Age: _____________ Gender: ____________________________

Address: ____

____

Home Phone:____________________________ May I leave a message? ☐ yes☐ no

Cell: ________________________________ May I leave a message? ☐ yes☐ no

Work Phone:____________________________ May I leave a message? ☐ yes☐ no

E-mail: _______________________________May I e-mail you? ☐ yes☐ no

Emergency Contact Name/Relationship : ______________________________

Emergency Contact Phone Number: ________________________________

Name of Primary Care Provider: __________________________________

Primary Care Provider Contact Information: ___________________________

Initial below as indicated:

________ I provide authorization for Cynthia (Thea) Stanford, LMFT to communicate with my Primary Care Provider for the purpose of case collaboration

________ I do not provide authorization for Cynthia (Thea) Stanford, LMFT to communicate with my Primary Care Provider

What method of payment will be used? (Initial as indicated)

______ I am paying out-of-pocket

______I am using health insurance benefits

Health Insurance Company: ____

Name of Policy Holder: ____

Policy Holder D.O.B.: ____________________Relationship to client: ____________________

Insurance ID #: ________________________Group #: ______________________________

Initial below as indicated:

________: If self-paying:
I understand I am financially responsible for all services, charges, and fees

_______: If using insurance benefits:
I hereby authorize my insurance benefits to be paid directly to Cynthia Stanford, LMFT for services rendered. I authorize the release of any information as required by my insurance company or other reimbursing agency. I understand I am financially responsible for the charges not covered by my insurance company.

Some find it convenient to put a credit card on file. This can be helpful when adolescents attend appointments alone, or when clients have busy schedules or late appointment times. Please note that **you are not required to provide this information.**

Cardholder Name: ____

Visa/Mastercard (please circle) Number: ____

Expiration: _____________V-code: _______________ Billing zip code: ________________

I authorize my credit card to be billed by Cynthia Stanford, LMFT, for all copays, fees, and services rendered that are not covered by my insurance company

____

Cardholder Signature

____ _____________________________

Signature of client Date

Section 2: Demographics and Living Situation

Please list current family members including your partner and any children

Name	Age	Gender	Relationship to you	Additional Comments

Please describe your current living situation ____

____

____

Relationship Status: ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widowed

☐ Dating ☐ Single ☐ Other (describe): ____

Ethnicity: ____

Native Language: ____

Are you adopted? ☐ yes ☐ no If yes, at what age? _________________________________

Gender Identity: ____

Sexual Orientation: ____

Religious/Spiritual Affiliation: ____

Highest Level of Education:____

Current Student? ☐ yes ☐ no Comments: ____

____

Military Veteran? ☐ yes ☐ no Comments: ____

____

Employment status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Looking for work ☐ Disabled

☐ Unemployed ☐ Other (describe): ____

Employer (if applicable): ____

Job Description (if applicable:) ____

____

Financial concerns: ☐ yes ☐ no If yes, describe: ____

____

Legal Issues: ☐ current ☐ past ☐ never Describe: ____

____

Any additional information related to your identity that you would like me to know at this time:

____

____

Section 3: Current Concerns

Why are you seeking therapy at this time? ____

____

____

____

____

____

____

Please check any symptoms you have experienced within the past month

☐Difficulty sleeping (please describe): ____________________

☐ Loss of interest in activities you used to enjoy ☐Difficulty getting out of bed

☐ Withdrawing from others ☐Isolation ☐Anger outbursts ☐Depressed mood

☐Difficulty leaving home ☐Feeling of numbness ☐Irritability ☐Anxiety

☐Hopelessness ☐Helplessness ☐Sadness ☐Panic ☐Fear ☐Frequent guilt

☐Racing thoughts ☐Frequent worry ☐Decreased energy ☐Worthlessness

☐Avoidance of people, places, activities, or specific things

☐Fear of certain objects or situations (please describe): ____________________

☐Repetitive behaviors (please describe):____________________

☐Concerns with eating (please describe:) ____________________

☐Difficulty concentrating ☐Intrusive memories ☐Frequent nightmares

☐A feeling of being separate from your body ☐Abuse in your relationship

☐Feeling unsafe in your home ☐Relational difficulties ☐Difficulty expressing emotions

☐Difficulty saying no to others ☐Feeling out of control ☐Ineffective communication

☐Sexual concerns ☐Unusual visual or auditory experiences ☐Self-harming behaviors

☐Thoughts about harming yourself ☐Thoughts about harming someone else

☐Other (please describe): ____________________

Section 4: Mental Health History

If applicable, please list any mental health treatment history, dates of treatment, and issues addressed at that time:

____

____

____

____

Are you currently prescribed any psychoactive medications? ☐ yes ☐ no

If yes, please complete the chart

Medication	Dose	Start Date	Condition Treated
1)			
2)			
3)			
4)			

Have you recently discontinued any psychoactive medications? ☐ yes ☐ no

If yes, please describe: ____

Do you have any family history of mental health issues, including drug or alcohol dependency? Include parents, siblings, grandparents, aunts, uncles, and cousins:

____

____

Additional Comments regarding mental health history: ______________________

____

Section 5: Substance Use

If applicable, please describe your use of each of the following. Please include age at first use, time of most recent use, heaviest use, current use, and routes of administration.

Caffeine: ____

____

Nicotine: ____

____

Alcohol: ____

____

Marijuana: ____

____

Hallucinogens (LSD, Mushrooms, PCP, etc): ____

____

Stimulants (Cocaine, Crack, Methamphetamine, etc): ________________________________

____

Depressants (Heroin, Oxycontin, benzodiazepines, etc): _____________________________

____

Other substances not yet mentioned: ____

____

Do you think you have a problem with drugs or alcohol? ☐ yes ☐ no

Have others in your life expressed worry about your use of drugs or alcohol? ☐ yes ☐ no

Has your use of drugs or alcohol negatively impacted your relationships, employment, or other areas of your life? ☐ yes ☐ no If yes, describe: ______________________________________

____

Section 6: Physical Health

How would you describe your physical health? ☐ Poor ☐ Below Average ☐ Average ☐ Good ☐ Excellent

List any current medical conditions or concerns: ______________________________________

____

____

Allergies: ____

Do you have any concerns with your nutritional or exercise habits? ☐ yes ☐ no

Describe: ____

____

Section 7: Trauma History

Are there any events or relationships that you have experienced as traumatic in your life?

☐ yes ☐ no

If you answered yes and you feel comfortable doing so at this time, please describe: __________

____

____

If you answered yes, are you interested in addressing your trauma(s) in therapy? ☐ yes ☐ no

Section 8: Strengths

What do you consider to be your personal strengths?_______________________________________

____

What activities do you participate in and/or enjoy?____

____

Describe your support network: ____

____

Is there any other information you would like me to know at this time? ______________________

____

____