CLIENT INFORMATION

Name ____________________________________ **Today's Date** ____________

Date of Birth _____________________________ **Age** ______________

Address ____

City _________________________ **State** _________ **Zip** _____________________

If client is a minor, who is the responsible party? Please give name and address.

___

Phone (Home) ___________________________ **(Cell)** ______________________

Education ____

Occupation ______________________________ **Employer** _________________

Number of years on job ____

Who referred you? ____

Contact in case of an emergency:

Name ____________________________________ **Relationship** ______________

Phone (Home) ___________________________ **(Cell)** _____________________

Relationship Status (Please check all that apply):

Single ______ **Married** _______ **Separated** _________ **Divorced** _________

Widowed _________ **Living Together/Not Married** __________

Previous Marriages/Divorce Dates __________________________________

Names, ages, and sex of children (if applicable):

____

____

____

Name of physician ____

Date of last exam ____

Medical problems/Illnesses ____________________________________

____

Medications being taken _______________________________________

____

Surgeries ____

Previous Therapy:

Name of therapist _________________________ **Dates** ______________

Name of therapist _________________________ **Dates** ______________

Was it a positive experience? ___________________________________

Current issues/Problems for therapy _____________________________

____

____

Goals for outcome of therapy ___________________________________

____

Family of Origin:

Parents and siblings in your family	Age	Sex	Marital Status
Father ________________________	____	____	________________
Mother ________________________	____	____	________________
Siblings ______________________	____	____	________________
________________________	____	____	________________
________________________	____	____	________________
________________________	____	____	________________

Who primarily raised you? ____________________________

What were the occupations of the person(s) who raised you? ______

____

Presenting Problems:

Symptoms:

- ___ Anger
- ___ Anxiety
- ___ Compulsive behaviors
- ___ Confusion
- ___ Depression
- ___ Excessive use of alcohol or drugs
- ___ Headaches
- ___ Hopelessness
- ___ Impulse to hurt self/others
- ___ Irritability
- ___ Lack of energy
- ___ Loss of interest
- ___ Memory Loss
- ___ Mood Swings
- ___ Nausea/Vomiting
- ___ Self-critical
- ___ Seizures
- ___ Shortness of breath
- ___ Sleep difficulties

____ Disorientation (moments of not knowing where you are)
____ Visual or auditory hallucinations
____ Suicidal thoughts
____ Suspiciousness
____ Thought disorder
____ Obsessive preoccupations/ thoughts
____ Weight gain/loss
____ Medical problems

Couple Relationship:

____ Tension
____ Arguments
____ Emotional distance
____ Sexual difficulties
____ Communication problems
____ Alcohol or addiction problems
____ Stress from health problems
____ No couple relationship, which is ____ ,is not ____ ,a problem

Children (please include names and ages if applicable):

____Tension
____ Angry interchanges
____ Children exhibiting behavioral problems
____ Children exhibiting emotional problems
____ Problems in relationship between siblings
____ Health problems
____ No children, which is ____ , is not ____ , a problem

Extended Family:

____ Recent losses
____ On-going difficult interactions with ______________________________

Work/School:

____ Upsetting interactions
____ Financial insecurity

Community:

____ Insufficient friendships
____ Tension in friendships
____ Over-extended in friendships or community role
____ Other

BACKGROUND INFORMATION:

Type of work you do:

Interests, recreational activities, and hobbies:

What you like to do when you have spare time at home:

Community involvement(s) (neighborhood, religious, political, etc.):

About how many friends would you say you have?

Health and medical difficulties, past and present:

What kind of child were you?

What kind of teenager were you?

What kind of family did you grow up in?

I HAVE BEEN OFFERED A COPY OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) PRIVACY RULE AND I UNDERSTAND MY RIGHTS AS A CLIENT.

Client Signature ____
Date ___________________________
Name of minor if applicable ____

CONFIDENTIALITY PREFRENCES:

Please specify your preferences with regard to your communications initiated by Avery Neal. Please circle yes or no and print numbers and addresses only if you wish them to be used.

Name ____
Is it alright to call your cell phone? Yes No
Is it alright to leave messages on your cell phone? Yes No
Is it alright to call your home phone? Yes No
Is it alright to leave messages on your home phone? Yes No

It is alright to send billing statements and/or other correspondence to the following address:
____
____

Signature _______________________________________ Date ________________

CREDIT CARD AUTHORIZATION

IT IS REQUIRED FOR ALL PATIENTS TO KEEP A CREDIT CARD ON FILE.

I authorize that my credit card may be charged automatically with each session or telephone session I have with Avery Neal, MA, LPC. I am also authorizing that my credit card may be charged for sessions that are not cancelled 24 hours before my scheduled session.

SIGNATURE: ____