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: _____