

CONFIDENTIAL CLIENT INFORMATION

Welcome to my practice. Please answer the questions to the best of your ability. The information will help us work together. Thank you.

Date: _____ **E-mail Address:** _____

Name:

(First) (Middle) (Last)

Address:

(Street) (City) (State) (Zip Code)

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Age: _____ **Date of Birth:** _____ **Place of Birth:** _____

Circle One: **Single** **Married** **Long-Term Relationship** **Widowed**

Gender: _____ **Highest Education Level Completed:** _____

Are you currently a student? Y/N **If yes, where?** _____

Occupation: _____ **Employer:** _____

Emergency Contact Person: _____ **Phone:** _____

Who referred you or how did you hear about my counseling services?

Please list any ethnic, cultural and/or spiritual background that you would like me to be aware of:

What is your present living situation? (Check all that apply)

Live alone _____ **Spouse** _____ **Partner** _____ **Children** _____ **Other** _____

Abby Leach LMHC
Counseling & Consultation Services PS Inc
WA License# 5935

Do you have any children? _____

Name Age Living at home If not, where? Illnesses or special needs?

Do you have brothers or sisters?

Name Age Living with you If not, where? Do you get along?

Who is your primary care physician? _____ How long? _____

Date of last medical physical exam? _____

Do you have any concerns about your physical health (past/present)?

Do you have any medical conditions (past/present)?

Are you currently taking any medications? Y/N

Medication Dose Prescribing Physician

Vitamins/Supplements?

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Any allergies? If yes, please list:

Is there a family history of medical problems including mental illness, cancer, heart disease, chronic long-term illness, diabetes, etc.?

Do you have any sleeping problems? Y/N

If yes, please describe: _____

How many hours a night do you sleep? _____ Difficulty falling asleep? _____

Do you have any nightmares? Y/N How often? _____

Briefly describe the issues that are important to you. Please mention any ambitions, difficulties, challenges, etc. even if they seem unimportant.

Estimate how long these issues have been important to you? _____ (mos./yrs.)

What avenues have you explored to work on them?

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Have you had previous counseling/psychotherapy or psychiatric care in the past? Y/

N _____

When:

With Whom:

Please share your reasons for seeking therapy at this time. (If different than what you've described above.)

Upon completion of therapy, what is at least one thing that will tell you therapy was successful?

What is the most important thing about yourself you want me to know?

Please describe your support system and self-care. (If any)

BILLING INFORMATION

**** AS A CONSUMER OF THERAPY, YOU ARE RESONSIBLE FOR OBTAINING YOUR
BENEFITS INFORMATION AND INFORMING THE THERAPIST**

Primary Insurance Carrier: _____

Billing Address: _____

Name of Policy Holder: _____ **SSI #** _____ **D.O.B.** _____

Address: _____

Home Phone: _____ **Business Phone:** _____

Employer/School: _____ **Occupation:** _____

Policy # _____ **Group #** _____

Benefits if known: (# of sessions per calendar year) _____

Deductible? _____ **Amount met for this year?** _____

Secondary Insurance Carrier: _____

Billing Address: _____

Name of Policy Holder: _____ **SSI #** _____

Address: _____

Home Phone: _____ **Business Phone:** _____

Employer/School: _____ **Occupation:** _____

Policy # _____ **Group #** _____

Benefits if known: (# of sessions per calendar year) _____

Deductible? _____ **Amount met for this year?** _____