

CLIENT INFORMATION

- Please print legibly -

I. CLIENT DEMOGRAPHICS

Name _____ Client No _____
(therapist will complete)
Address _____
City _____ State _____ ZIP _____
Mailing Address (if different) _____
Phone Home _____ Work _____ Cell _____
Email _____

Sometimes it may be necessary to contact you to reschedule appointments, etc. Please be assured that any messages or conversations with other people will be done with the utmost discretion. No information is provided about you or the nature of the call.

	<u>Home</u>	<u>Work</u>	<u>Cell</u>
May a message be left with a person?	Y N	Y N	Y N
May a message be left on a machine?	Y N	Y N	Y N
When are the best times to call?	_____	_____	_____

Birth Date _____ Soc Sec No _____

Gender Male Female MTF Transsexual FTM Transsexual Intersexual

Orientation Gay Straight Bisexual Questioning Other _____

Relationship Status: _____ Single _____ Separated
_____ Married/Partnered _____ Divorced/Relationship Dissolved
_____ Children (Ages & Gender: _____)

Living With _____ Relationship _____

Emergency Contact _____ Phone _____

Relationship to you _____

Currently Employed? Y N Employer's name _____ Full Part

Currently in School? Y N Where? _____ Full Part

Ethnicity How do you identify yourself in terms of race or ethnic background?

Religion Do you have a religious affiliation? Y N

(If yes, please identify the major denomination and the specific group, if applicable.)

Eddie Edmondson, LICSW
613 19th Ave E - Ste 102

Seattle WA 98112

Psychotherapist
206.322.5733

Date: _____

Name _____

Client No _____

2. MEDICAL INFORMATION

Primary Care Doctor _____ Phone _____

Address _____

May I contact your doctor to coordinate care, as appropriate? Y N

Current Height _____ Weight _____ General Health: Good Fair Poor

Date of last physical exam _____ Any **current** problems? Y N (If yes, explain)

Do you have any allergies? Y N (If yes, identify below)

Are you allergic to any medications? Y N (If yes, identify below)

Are you **currently** taking any medications for **medical** reasons? (Psychiatric meds come later) Y N

Medication Name	Reason	Dosage	Frequency	Date Started
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Medical Problems (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleep (hrs/night _____) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Speech Difficulties |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Hearing | <input type="checkbox"/> Stomach/Vomiting |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Handicap _____ |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Muscle/Joint Pain | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> Other _____ |

Are you seeing doctors for any of these problems, **other than** your primary care doctor? Y N

Doctor's Name _____ Phone _____

Doctor's Name _____ Phone _____

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Date: _____

3. MEDICAL INSURANCE INFORMATION

Will you be using the mental health benefit of your medical insurance? Y N

If yes, please provide the following information about your insurance:

Company Name _____

Group Number _____

Individual Number _____

Phone Number _____

Contact Person _____

Benefit Information Copay \$ _____ per visit Coinsurance _____%
Max Benefit \$ _____ Max Visits per Calendar Year _____
Deductible \$ _____

Claims Address _____

Managed Care Org Name _____
Phone _____
Preauthorization Required Y N

Other Information _____

4. EDUCATION HISTORY

Completed high school? Y N If no, what grade completed? _____

Any college? Y N If yes, how much? _____ Degree _____

Graduate education or degrees? Y N (*If yes, explain*) _____

Any problems in school? Y N (*If yes, explain*)

5. MENTAL HEALTH HISTORY

Who referred you? _____

Have you had any counseling or therapy in the past? Y N *If yes, please answer the following:*

With whom? _____

Where? _____

When? _____

For what reasons? _____

Are you **currently** taking **mental health** medications? Y N *If so, indicate name and dose.*

<i>Medication Name</i>	<i>Reason</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Date Started</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who prescribes them? _____ Phone _____

May I contact your provider to coordinate care? Y N

Have you taken mental health medications **in the past**? Y N *If so, indicate what and when.*

<i>Medication Name</i>	<i>Reason</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Date Started</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What would you describe as the issue(s) that brought you into therapy?

6. SUBSTANCE USE

Current Use *(Include alcohol, tobacco, legal/illegal drugs)*

Type	Amount <i>(eg, 3-4)</i>	Frequency <i>(e.g, per day, week)</i>	When Start Using	Problem? <i>(Y N)</i>	Addicted? <i>(Y N)</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Currently in treatment? Y N

(If yes, explain: when started, where, inpatient or outpatient, type of treatment, AA or NA, etc.)

Past Use

Type	Amount <i>(eg, 3-4)</i>	Frequency <i>(e.g, per day, week)</i>	When Start Using	Problem? <i>(Y N)</i>	Addicted? <i>(Y N)</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Past treatment? Y N

(If yes, explain: when started, where, inpatient or outpatient, type of treatment, AA or NA, etc.)

7. PSYCHIATRIC HOSPITALIZATIONS

Have you ever been hospitalized for mental health reasons? Y N *(If yes, describe)*

Dates	Location	Reason(s)	Voluntary/Invol
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other information _____
