ANXIETY & STRESS CENTER

CLIENT FACE SHEET

NAME: _____

ASSIGNED SEX: _____ PREFERRED PRONOUNS: _____

DATE OF BIRTH: _____ AGE: _____ PLACE OF BIRTH: _____

ADDRESS: _____

REFERRAL SOURCE: _____

CONTACT INFORMATION:

HOME: _____ CELL: _____

OTHER: _____ FAX: _____

FOR ROUTINE MESSAGES: _____

EMAIL: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES:

PHONE_____ EMAIL: _____

IN CASE OF EMERGENCY:

NAME:_____ RELATION: _____

CONTACT INFORMATION: _____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring it with you to the first session.

If you do not desire to answer any question, merely write, "Do not care to answer."

NAME: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

SUICIDE ATTEMPT/S, SUICIDAL IDEATION, OR SELF-INJURIOUS BEHAVIOR:

VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):
USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.

RELATIONSHIP HISTORY

PAST & PRESENT MARRIAGE/S AND/OR SIGNIFICANT RELATIONSHIPS (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

CURRENT RELATIONSHIP STATUS:

Marital status: _____Sexual Orientation: _____

Partner Name: _____Years:_____

Partner's Education: _____

Partner's Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

FAMILY HISTORY

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

IF PARENTS SEPARATED OR DIVORCED:
Your age at the time:
Describe how it affected you at the time:

Stepparents:

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

EDUCATION/OCCUPATIONAL INFORMATION

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

OCCUPATION (former, if retired):

MEDICAL INFORMATION

MEDICAL DOCTOR(S) (name/phone):

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

ADDITIONAL INFORMATION

SPIRITUALITY (describe):

FRIENDSHIPS (describe):

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____

Work/School: _____ Other: _____

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

Please add, on to this page, any other information you would like me to know about you and your situation.

Signature on File

I understand that I am responsible for my bill.
I authorize use of this form for all my insurance submissions.
I authorize release of necessary information to all my insurance companies.
I authorize Anxiety & Stress Center, P.C. and its billing service to act as my agent in helping me obtain payment from my insurance companies.
I authorize direct payment to Anxiety & Stress Center, P.C.
I permit a copy of this authorization to be used in place of the original.
I understand that if my insurance does not pay for services rendered, I am responsible for my entire bill.

SIGNATURE_____ DATE_____

Coordination of Care

In an effort to coordinate your care, we routinely correspond with referring and treating physicians, including primary care physicians, gynecologists, internists, psychiatrists, and others. Please fill out the form below so that we may send summaries of treatment to your physician. Your signature below gives us permission to correspond with your treating physician while you are receiving services at the Anxiety & Stress Center, P.C. You may revoke this permission at any time.

Physician's Name _____

Address_____

_____
city state zip

Phone ( )_____Fax ( )_____

Signature_____Date_____