New Client Information and History

Welcome to *Soundview Health Associates*. Please complete this **Information and History** form as a way of orienting your psychologist to your needs. Be sure to complete both sides of the form.

During our first intake evaluation session, your reasons for seeking therapy will be discussed, as well as your personal and family health history. Any information relevant to understanding your situation, including past treatment you've sought, will be extremely helpful to our process. You'll know best what the full story is, so you don't need to limit our conversation to the areas on this history form or the things I ask you about specifically.

It may be that you decide as part of our early session(s) that you would prefer to see someone different, or it may be that I believe it best to refer you to someone else for ongoing care; this is a normal part of the process. Neither party need feel badly if the match isn't right. (In fact, for psychologists, this is part of our code of ethics.)

Full Name: _____ Date:_____

Gender _____ Birthdate _____ Ethnicity(ies) _____

Relationship status: _____

Others Living at home: _____

Address: _____ City: _____

State:_____ Zip: _____ Email:_____

My I mail to you at this address? Yes _____ No _____ May I E-mail you? Yes _____ No _____

Phone: Home (_____)_____ Wk (_____)_____ Cell (_____)_____

May I contact you and leave messages at these phone numbers? Which one(s)? _____

Your preference(s) for being contacted with a confidential message?: _____

In case of emergency, contact: _____ Phone: (_____)_____

Relationship to contact: _____

Employer: _____ How long have you worked there? _____

Occupation: _____ How long in this occupation? _____

Education (highest level attained): _____

Primary Care Physician: _____ Phone: _____

Please list any significant health problems: _____

List any medications you are taking & the dosage: _____

Have you ever met with a psychologist, psychiatrist, counselor or social worker in the past? Yes ____ No ____

(If Yes) When and with whom? _____

Please give a brief description of treatment: _____

Please list any medications for emotional health issues that you've been prescribed in the past (if any): _____

_____

Ever been hospitalized or received intensive treatment for emotional health concerns? Yes _____ No _____

If so, for _____ on (approximate date) _____

How did you learn of this therapy practice? _____

Who may we thank (if anyone) for referring you? _____

Will you use health insurance to pay for services? Yes ____ No ____ [*If not, skip questions about insurance*]

Insurance company _____ Do you have a limited # of sessions? Yes ____ No ____

Policy holder's name _____ Policy holder's DOB: _____

SSN or Identification #: _____ Your relationship to policy holder _____

Please check the statement that best describes how you're doing right now:
_____I am functioning well, but I am seeking therapy for personal growth and life improvement.
_____I am functioning quite well, but I have some concerns I'd like to prevent from becoming bigger issues.
_____I am functioning relatively well, but I am not feeling good and could use help sorting things out.
_____I'm experiencing problems that are negatively affecting how well I function in major area(s) of my life.
_____I feel as though I'm barely functioning much of the time.

Please describe your reason(s) for seeking therapy at this time. If there is a particular event which triggered your decision to seek treatment now, please list/describe the event:

_____

_____

_____

What result(s) do you expect or hope from therapy? _____

_____

Please check all those items that help describe your concerns. Star the ones that are particularly important to you.

_____Anxiety or nervousness in general
_____Panic attacks or intense fears
_____ Avoiding leaving your home or social anxiety
_____Personal growth issues
_____Social skills or loneliness
_____Relationship issues
_____Family issues
_____Self-esteem
_____Eating patterns
_____ Body image/weight concerns
_____ Sexuality patterns, (in)experience or desire
_____ Alcohol or drug use
_____ Desire to change a behavior
_____Managing impulses, making hasty decisions
_____Managing anger
_____Mood swings
_____Depression or feeling low
_____ Cutting, hitting, or burning yourself
_____Considering suicide
_____Sleeping too much or not enough
_____Nightmares
_____ Chronic pain or fatigue
_____ Stress Management
_____Grief in response to a death or loss
_____Help adjusting to a change in my life
_____ Recovering from a trauma
_____ Cultural identity
_____Sexual orientation
_____ Spiritual identity
_____ Gender identity
_____ Different identity issue:
_____Feeling detached from the world
_____Imagining things that are not real
_____Conflict with a friend, colleague, employer
_____Physical abuse
_____Emotional or verbal abuse
_____Sexual assault or abuse
_____Harassment
_____ Struggling to perform in career or school
_____Career planning issues
_____Perfectionism or procrastination
_____AD/HD or a learning disability
_____Physical disability or illness
_____ Other issue(s) Please desribe:

Thank you very much for completing this form.