Joanne Norman MA, LMHC

CLIENT INFORMATION

DATE: ____________________

A. IDENTIFICATION INFORMATION (CLIENT BEING SEEN)

Name: ______________________________ Date of Birth: ______________

Address____ Apt: _____ Home Phone: ____________________

City: ________________________ State: _____ Zip: _____________ Work Phone: ___________________

Employer: ____ Cell Phone: _____________________

Is it okay to leave messages on all of these phones? ☐ Yes ☐ No If not, which ones? ____________________

Would you like me to coordinate with you're: ☐ Doctor ☐ Attorney ☐ Other ____________________________

B. REFERRAL INFORMATION

How were you referred?

☐ Internet ☐ Snohomish County ☐ Insurance Company ☐ Doctor ☐ Friend

☐ Other____

May I have your permission to thank them for the referral? ☐ Yes ☐ No

C. INSURANCE INFORMATION (HOLDER OF INSURANCE POLICY IF DIFFERENT THAN ABOVE)

Your relationship to insured? ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name (if not self):____ Date of Birth: ____________

Home phone: ___________________________________

Address: ____________________________________ Apt: ______ City: ____________________ State: ____

Zip: __________ **(Please provide insurance card for clinician to copy)**

Employer: _________________________________ Insurance Plan Name: _____________________________

Do you have secondary insurance? ☐ Yes ☐ No If so, please fill out the following:

Insured's Name: ________________________________ Relationship to you: ___________________________

Date of Birth: ________ Social Security #:_____________________ Home phone: ______________________

Address: ______________________________________ Apt: _______ City: ________________ State: _____

Zip: __________ **(Please provide insurance card for clinician to copy)**

Employer: _______________________________ Insurance Plan Name: ______________________________

D. FAMILY INFORMATION

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widow/Widower

Number of children and their ages:
____

____

Are your parents: ☐ Divorced ☐ Never married ☐ still married ☐ Widowed

Where are you in the birth order of your family? ____

Personal or Family history of: (Mark P = personal & F = Family)

____Depression ____Suicide Attempts ____Anxiety

____Eating Disorders ____Mental Illness ____Violence

____Sexual Abuse ____Emotional Abuse ____Alcoholism/Drug Addiction

____Chronic Illness (please explain) ____

____Other ____

	Name	*Current Age or Age at Death*	*Illness (Cause of Death)*	*Education*	*Occupation*
Father					
Mother					
Siblings					
Children					
Spouse/Partner					

E. MEDICAL INFORMATION

Primary Physician: _________________________________Phone:________________ Last Exam: ___________

Major (or chronic) Operations/ Illnesses / Injuries ____

____

____

Current Medications Dosages Frequency Effectiveness Prescribing Physician

____

____

Have you experienced any recent changes in?

☐ Sleep ☐ Nightmare ☐ Amount of Exercise ☐ Sexual Desire ☐ Eating/Appetite ☐ Weight

How would you characterize your overall health?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Do you smoke? ☐ Yes ☐ No Smoke in the past? ☐ Yes ☐ No

Do you consume any alcohol? ☐ Yes ☐ No ☐ Less then 1x/mo ☐ 1-3x/mo ☐ 1x/week ☐ Every day
☐ Beer ☐ Wine ☐ Hard Liquor *(check all that apply)*

Do you use any street drugs or use prescription drugs without your doctor's knowledge? ☐ Yes ☐ No

Name of Drug(s) Frequency of Use Name(s) of Drug(s) Frequency of Use

____

____

F. Treatment Information

Please describe the main concern(s) that have prompted you to see me now? ____________________________

____

____

How long has this been a concern? ____

Please indicate you major life stressors of the past 12 months?

☐ Serious Illness or Injury ☐ Death of a Close Friend or Family Member ☐ Major Illness in Family

☐ Gain of New Family Member ☐ Divorce / Separation ☐ Job Change

☐ Other ____

Please describe what you would like to be different in your life when you are done with therapy?

____

____

Have you ever received psychological or psychiatric counseling before? ☐ Yes ☐ No

When? From Whom? Purpose? Results?

____

____

Have you ever been prescribed medication for a psychiatric or emotional problem? ☐ Yes ☐ No

When? Prescriber? What Medication? For What? Results?

____

____

Have you ever been hospitalized for a psychiatric or emotional health reason? ☐ Yes ☐ No

When? Where? For What Reason? Outcome?

____

____

Have you ever been in a drug or alcohol treatment program? ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient

When? How Long? Outcome?

____

____

G. Social / Relationship Information

Please indicate any of the following that you have experienced?

☐ Death of Mother Your age at occurrence _____

☐ Death of Father Your age at occurrence _____

☐ Death of Child Your age at occurrence _____ Child's Age_____

☐ Death of a Sibling Your age at occurrence _____ Sibling's Age_____

☐ Desertion by mother as a child Your age at occurrence _____

☐ Desertion by father as a child Your age at occurrence _____

☐ Divorce of parents Your age at occurrence _____

☐ Sexual abuse ☐ Emotional Abuse ☐ Physical abuse

☐ Violence in the family ☐ Mental Illness of a family member

Who are the most significant supports in your life? *(Check all that apply)* ☐ Spouse / Partner ☐ Friends

☐ Parent(s) ☐ Siblings ☐ Children ☐ Other _______________________________________

H. Employment Information

What is the nature of your employment? ______________________________ How long at current job? _____

How satisfied are you in this job?

☐ Not very satisfied ☐ Somewhat satisfied ☐ Comfortable ☐ Very Satisfied

I. 1. CULTURAL (EXPAND BEYOND ETHNICITY AND INCLUDE SOCIOECONOMIC, RELIGION, GEOGRAPHIC ETC…)

____

2. Spiritual Resources (HOW SIGNIFICANT A ROLE DOES SPIRITUALITY PLAY IN YOUR LIFE)?

☐ None ☐ Somewhat important ☐ Significant ☐ Very Significant

J. Other

Is there anything else you think I should know about?

____

____

____