



Darcy R. Greene M.A., LMFT
Crossroads Counseling

*Healing from the Past,
 Help for the Present,
 Hope for the Future*

PATIENT INFORMATION
 (Please print clearly)

PATIENT'S NAME _____		Date of Birth _____	Age _____	Sex _____
<input type="checkbox"/> Minor	<input type="checkbox"/> Unmarried	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Address _____		Email _____		
Number & Street	City	State	Zip	Okay to Leave Message? Yes No
Occupation _____	Home Phone () _____		<input type="checkbox"/>	<input type="checkbox"/>
Patient's Employer _____	Work Phone () _____		<input type="checkbox"/>	<input type="checkbox"/>
Name _____		Cell Phone () _____		<input type="checkbox"/>
Address _____				
SPOUSE'S OR PARENT'S NAME _____		Date of Birth _____	Age _____	
Occupation _____		Home Phone () _____		<input type="checkbox"/>
Patient's Employer _____		Work Phone () _____		<input type="checkbox"/>
Name _____		Cell Phone () _____		<input type="checkbox"/>
Address _____				
CLOSEST FRIEND OR RELATIVE, NOT LIVING AT YOUR HOME, TO CONTACT IN EVENT OF EMERGENCY				
Name _____		Relationship _____		Phone () _____
Last		First	Middle	
Address _____		City _____		State _____ Zip _____
Number & Street				
PARTY TO TAKE FINANCIAL RESPONSIBILITY FOR COUNSELING (If same as "patient" indicate "self")-Must sign at bottom				
Name _____		Relationship _____		Phone () _____
Last		First	Middle	
Insurance Company _____		Member I.D. _____		
Group # _____		Social Security # _____		
Address _____		City _____		State _____ Zip _____
Number & Street				

Education:

<input type="checkbox"/> High School Grad/GED			
<input type="checkbox"/> Vocational	Number of Years: _____	Graduated: Yes <input type="checkbox"/> No <input type="checkbox"/>	Major: _____
<input type="checkbox"/> College	Number of Years: _____	Graduated: Yes <input type="checkbox"/> No <input type="checkbox"/>	Major: _____
<input type="checkbox"/> Graduate	Number of Years: _____	Graduated: Yes <input type="checkbox"/> No <input type="checkbox"/>	Major: _____

Reasons for Seeking Therapy:

Briefly describe the problem(s) you are experiencing:

Current Functioning:

1. Are you presently being treated by a therapist?

Yes No

If yes, explain:

2. Are you currently feeling suicidal?

Yes No

If yes, explain:

3. Have you ever seriously contemplated suicide?

Yes No

If yes, when:

4. Have you ever attempted suicide?

Yes No

If yes, when:

5. Have you ever had thoughts of attempts of self-harm (cutting, self-mutilation etc.

Yes No

If yes, explain:

6. Are you currently involved in any active legal cases or actions? (traffic, family law, civil, criminal)

Yes No

If yes, explain:

Marital History:

If Have you been previously married/co-habiting please complete the following:

1st Marriage: Date Began: _____

Date Ended: _____

Ex-spouse's name: _____

Children: Yes No

Reason for Ending: (If divorce, why?)

2nd Marriage: Date Began: _____

Date Ended: _____

Ex-spouse's name: _____

Children: Yes No

Reason for Ending: (If divorce, why?)

3rd Marriage: Date Began: _____

Date Ended: _____

Ex-spouse's name: _____

Children: Yes No

Reason for Ending: (If divorce, why?)

Family Information:

Do you have children?	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
Name:	Gender:	Age:	Type (Bio, Step, etc.)	Living with you?		
_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

If your child(ren) are not living with you please list where they live and how often you see them:

City/State:	Lives With:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

Have any relatives (parents, grandparents, uncles, aunts, cousins) ever had any of the following conditions:
If yes, who?

Substance Abuse or Addiction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Suicidal Thoughts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Panic Attacks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Learning Disability	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
A.D.D./A.D.H.D.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Mental Retardation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Schizophrenia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Bipolar	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Eating Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Sexual Addiction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Arrests	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Mental Health History:

1. Have you ever seen a psychiatrist, therapist or counselor?

Yes

No

When?

For What?

What did you like about the experience?

What did you not like about the experience?

2. Have you ever been on medication for behavioral or emotional problems?

Yes

No

If yes, which one(s):

3. Have you ever been hospitalized for psychological reasons?

Yes

No

If yes, list reasons and date(s):

Medical History:

1. How is your basic health?

Good Fair Poor

Date of last physical exam? _____

Physical Health Issues

None at this time Yes

If yes, please explain:

2. Have you had any head injuries?

Yes No

If yes, when? _____

3. Are you taking any prescription medications?

Yes No

If yes, what?

4. Are you taking any over the counter medications? Yes No

If yes, what?

5. Have you ever been hospitalized?

Yes No

If yes, for how long? _____

If yes, for what?

6. Are there any physical, emotional, chronic illness, medical or mental conditions now or in the past I need to be aware of?

If yes, please explain:

Social Relationships and Spiritual Background:

1. How would you describe the way you generally are with other people?

- Affectionate Aggressive Avoidant Fight/Argue Often Follower Submissive
 Friendly Leader Outgoing Shy/Withdrawn Other (Specify) _____
 Organized Flexible Structured "Go with the Flow"

2. Are you affiliated with a spiritual or religious group?

Yes No

If yes, please describe:

3. Do you have a home church, synagogue or place of worship?

Yes No

4. Where you raised within a spiritual or religious group?

Yes No

If yes, please describe:

5. Would you like your spiritual/religious beliefs incorporated into your counseling?

Yes No

Substance Abuse and Addictions:

Name of Drug	Used	Age 1 st Used	Frequency	Amount	Last Used?
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Cigarettes/Nicotine	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Methamphetamine	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Non-Medical Use of Prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Hallucinogen	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Pornography	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Sex	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No				

1. Substance of Preference: 1. _____ 2. _____ 3. _____

2. Describe when you are most likely to use:

Is there anything else you would like me to know about you?



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Darcy R. Greene MA, LMFT (MFC #53395)
Crossroads Counseling
Licensed Marriage Family Therapist

Credit Card/Debit Payment Agreement

To facilitate compliance with the insurance billing process I am providing the following credit or debit card to be kept on file. I understand that without this completed form Crossroads will not bill my insurance and I will need to pay for services in full at the time they are rendered. This form is valid through the expiration date on the card, unless I cancel the authorization through a written notice to this organization.

Client Name: _____ **(PLEASE PRINT)**

I authorize the administrative staff of Crossroads Counseling to charge the listed credit card for future services provided by the therapist named above starting _____ (date). This includes billing me for unpaid copay's, deductibles and appointments missed or not canceled with 48 hours' notice.

Credit Card Information **(ALL INFORMATION IN THIS SECTION IS REQUIRED)**

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ Security Code: _____ (3 digit code on the back of card)

Billing Street Address: _____

Billing Zip Code: _____

Name as is appears on Card: _____

(Please Print)

Client Signature: _____ Date: _____

Email Address to Send Receipt To: _____