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

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PATIENT INFORMATION
(Please print clearly)

PATIENT'S NAME _____ Date of Birth _____ Age _____ Sex ____
Last First Middle

☐ Minor ☐ Unmarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address _____ Email _____
Number & Street City State Zip Okay to Leave Message? Yes No

Occupation _____ Home Phone ( )_____ ❑ ❑

Patient's Employer _____ Work Phone ( )_____ ❑ ❑
Name

_____ Cell Phone ( )_____ ❑ ❑
Address

SPOUSE'S OR PARENT'S NAME _____ Date of Birth _____ Age _____
Okay to Leave Message? Yes No

Occupation _____ Home Phone ( )_____ ❑ ❑

Patient's Employer _____ Work Phone ( )_____ ❑ ❑
Name

_____ Cell Phone ( )_____ ❑ ❑
Address

CLOSEST FRIEND OR RELATIVE, NOT LIVING AT YOUR HOME, TO CONTACT IN EVENT OF EMERGENCY

Name _____ Phone ( )_____
Last First Middle Relationship

Address _____
Number & Street City State Zip

PARTY TO TAKE FINANCIAL RESPONSIBILTY FOR COUNSELING (If same as "patient" indicate "self")-Must sign at bottom

Name _____ Phone ( )_____
Last First Middle Relationship

Insurance Company_____ Member I.D._____

Group # _____ Social Security #_____

Address _____
Number & Street City State Zip

Education:

❑ **High School Grad/GED**
❑ **Vocational** **Number of Years:**_____ **Graduated:** Yes ❑ No ❑ **Major:**_____
❑ **College** **Number of Years:**_____ **Graduated:** Yes ❑ No ❑ **Major:**_____
❑ **Graduate** **Number of Years:**_____ **Graduated:** Yes ❑ No ❑ **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-multination 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-habitating 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 ❑ No ❑

Name:	**Gender:**	**Age:**	**Type** (Bio, Step, etc.)	**Living with you?**	
_____	_____	_____	_____	Yes ❑	No ❑
_____	_____	_____	_____	Yes ❑	No ❑
_____	_____	_____	_____	Yes ❑	No ❑
_____	_____	_____	_____	Yes ❑	No ❑
_____	_____	_____	_____	Yes ❑	No ❑
_____	_____	_____	_____	Yes ❑	No ❑
_____	_____	_____	_____	Yes ❑	No ❑

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 ❑	No ❑	_____
Depression	Yes ❑	No ❑	_____
Suicidal Thoughts	Yes ❑	No ❑	_____
Anxiety	Yes ❑	No ❑	_____
Panic Attacks	Yes ❑	No ❑	_____
Learning Disability	Yes ❑	No ❑	_____
A.D.D./A.D.H.D.	Yes ❑	No ❑	_____
Mental Retardation	Yes ❑	No ❑	_____
Schizophrenia	Yes ❑	No ❑	_____
Bipolar	Yes ❑	No ❑	_____
Eating Disorder	Yes ❑	No ❑	_____
Sexual Addiction	Yes ❑	No ❑	_____
Arrests	Yes ❑	No ❑	_____

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 1st Used	Frequency	Amount	Last Used?
Caffeine	❑Yes ❑No				
Cigarettes/Nicotine	❑Yes ❑No				
Alcohol	❑Yes ❑No				
Marijuana	❑Yes ❑No				
Methamphetamine	❑Yes ❑No				
Cocaine	❑Yes ❑No				
Inhalants	❑Yes ❑No				
Non-Medical Use of Prescription drugs	❑Yes ❑No				
Hallucinogen	❑Yes ❑No				
Other Drugs	❑Yes ❑No				
Pornography	❑Yes ❑No				
Sex	❑Yes ❑No				
Food	❑Yes ❑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: _____