Eagle and Boise Counseling
787 E State St. Suite 130
Eagle, Idaho 83616

CLIENT INFORMATION			
Full Name: Name that you like to be called (nickname):		Relationship Status: □ S □ M □ D □ Sep □ W	
Date of Birth:	Age:	Sex: □ M □ F	
Occupation:			
Employer/Company Name: Work Address:			
Home Address w/zip code: Ok to mail to this address? □ Yes □ No	Email: Ok to email? □ Yes □ No (Please note that email correspondence is not guaranteed to be confidential)		
Home Phone#:	Cell Phone#:	Work Phone#:	
Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No	
Have you previously attended therapy? □ Yes □ No What kind of therapy? Inpatient /Outpatient/ Other: _____	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?	

BIOPSYCHOSOCIAL HISTORY			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Depressed Mood	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Appetite Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High

Change in Energy Level	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Worthless/Helpless Feelings	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety Symptoms/ Panic Attacks	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Feelings of Guilt	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Obsessions/ Compulsions	□Yes	□ No	If "Yes", please describe:
Phobias	□Yes	□ No	If "Yes", please describe:
Medical Conditions	□Yes	□ No	If "Yes", please describe:
Hyperactivity	□Yes	□ No	If "Yes", please describe:
Are you having suicidal thoughts?	□Yes	□ No	If "Yes", do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	□Yes	□ No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	□Yes	□ No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	□Yes	□ No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a therapist or psychiatrist?	□Yes	□ No	If yes, please list the diagnosis's and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

1.
2.
3.
4.

List anything other medications or comments that your therapist should be aware of regarding your physical or mental health:

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Substance Use		
Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever been arrested for a DUI, or drug use? Or do you have a past that involves using drugs or alcohol. Please briefly describe circumstances below:	□Yes	□ No

Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Spouse/Partner	_____	_____	____	____
Parent	_____	_____	____	____

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Parent	_____	_____	____	____
Stepparent	_____	_____	____	____
Stepparent	_____	_____	____	____
Sibling	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
Children/Step	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____

Are your parents divorced? □ Yes □ No Remarried? □ Yes □ No

Religion (if any) _____

Sexual orientation _____

Gender orientation_____ (female, male, transgender, transsexual)

Ethnic Group (select all that apply):

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American Indian Alaskan Native Caucasian Middle Eastern
Asian Phillipino Native Hawaiian Pacific Islander Hispanic/Latino
Black/African American Multi-Ethnic/Other_____

Family of Origin (Circle Your Answer)

Have you experienced any abuse in your family or relationships?

None Emotional Physical Sexual Uncertain

In general, how happy were you growing up?

None Somewhat Mostly Extremely

How much is your family of origin a source of support for you?

None Somewhat Very Extremely

How much conflict in values do you experience with your parents?

None Somewhat Substantial

Legal Issues

Have you personally experienced legal problems? □ No □ Yes (describe)

Are you currently involved in a lawsuit? If so please describe:

Briefly describe concerns in your life and/or in your relationships that would be relevant for your therapist to know. You may use the back of the form for more space if needed:

On a scale of one to ten, how motivated are you to resolve this issue? _____

Please list your therapy goals (list as many that apply & use the back if need be):

1.

2.

3.

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required on the last page before we can begin our work together. Please discuss any questions you may have with your therapist prior to signing.

Client Signature Page for Informed Consent For Therapy
Eagle and Boise Counseling, Inc.
Licensed Marriage and Family Therapists

- **I have thoroughly read and fully understand the Informed Consent and the therapy policy pages of this document.**
- **I understand that I am financially responsible for charges and fees incurred. And I agree to honor the 72-hour cancellation policy.**
- **I understand limits of confidentiality and all mandated reporting by my therapist.**
- **I understand that any disclosures of sex with a minor, viewing underage pornography, or sexual behavior with minors (a person under the age of 18) is reportable under law by all EAGLE AND BOISE COUNSELING therapists.**
- **I agree to respect the boundaries of contact between sessions and understand email and text is not an appropriate form of processing what is best discussed in session.**
- **I understand that emailing, texting and cell phone are not guaranteed as confidential.**
- **I understand and agree to the illness policy and will conduct sessions via phone if I am ill and agree that if my therapist is ill, she/he will conduct via phone.**
- **I understand and agree to the social media boundaries and policy.**
- **I have answered all questions in full, truthfully and to the best of my knowledge.**
- **I have had all questions about this document answered and sign willingly.**
- **I authorize my therapist employed with Eagle and Boise Counseling, Inc. to provide psychotherapeutic treatment for me, the client, signing below:**

- **Credit Card Number**_____

I authorize Eagle and Boise Counseling to charge my credit card after each session.

Signature
_____**Date**_____

- **Expiration** _____ **3digit code on back** _____ **Zip Code**_____

- **Insurance Information: Phone Number Address**

- **Insurance provider**_____

- ID#----------

- group#----------

- Who is the primary holder _ _____
  Date of birth_____

- Driver's License Number_____
- Expiration _____
- Client's name (printed): _____
- Client's signature: _____ Date _____
- Therapist's name (printed): _____

Therapist's signature: **Date**:

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