Heather Brooke, LPC

Colorado/Georgia/Tennessee
heathermeyerlpc@gmail.com
970-430-6552

CLIENT INFORMATION

Name_____ Phone _____

Address _____

Date of Birth_____ Age_____ Gender: Male_____ Female_____

INSURANCE INFORMATION

Insurance _____ Member ID _____

Group Number _____ Copay _____

Subscriber Name _____ Subscriber Date of Birth _____

Relationship to Subscriber: Self Spouse Child Other _____

****Credit Card Information (Required In Event of Late Cancel/No Show)**

Card Type: Visa MC Disc Amex Card Number _____

Exp Date _____/_____ CV Code _____ Billing Zip Code _____

Name On Card _____

Authorization Signature _____

(By signing the above authorization, you are giving permission to charge your card the full session fee for a cancellation of less than 48 hours or a no show)

MEDICAL HISTORY

Current medications:

1)_____ Dosage/Freq_____ Start Date_____

2)_____ Dosage/Freq_____ Start Date_____

3)_____ Dosage/Freq_____ Start Date_____

4)_____ Dosage/Freq_____ Start Date_____

Prescribed by_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle One) YES NO

Hospital Mo/Yr Reason

_____

_____

_____

_____

Do you have allergies? (Circle One) YES NO

Do you have asthma? (Circle One) YES NO

Do you/have you use(d) recreational drugs or alcohol?

Type of Drug or Alcohol How Much How Often

_____ _____ _____

_____ _____ _____

_____ _____ _____

Describe any important medical history, chronic ailments or other health problems you experience:

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Did/Have you experience(d) any developmental, academic or behavior problems as a child or while in school with peers or teachers? (Circle One) YES NO If yes, please explain_____

What was the last year of school you completed? (Circle One) Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12 13+

Please list school currently attending if applicable_____

Describe any history of family problems, sexual/physical/emotional abuse, family drug use, etc:

MARITAL HISTORY

Marital Status ___Single/Never Married ___Married ___Separated ___Divorced ___
Widowed ___Living w/Someone ___If married, how long?_____

# of Children _____ Names & Ages_____

_____

_____

MENTAL HEALTH CHECK

Please check that currently apply:

___sad ___anxious ___depressed ___frightened ___guilty ___angry ___ashamed ___

aggressive ___resentful ___worthless ___tearful ___irritable ___confused ___

extreme ups/downs ___jealous ___hopeless ___helpless ___

What activities or hobbies do you participate
_____

_____

Do you participate in regular exercise? (Circle One) YES NO
Describe_____

Describe your current working environment_____

Have you had any change in sleep habits?_____

Have you had any change in eating habits?_____

Have you ever considered suicide in connection to your current problem?

Have you ever considered suicide in the past?

Have you attempted suicide recently or in the past?

Have you had any homicidal thoughts recently or in regard to your current problem?

Have you ever considered homicide in the past?

Is there any other information regarding you or your family that you would like to share with your therapist that is not covered on this form?

What has brought you specifically in for counseling?