Kristy Malone, LMFT, NTP

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Today's Date _____/_____/_____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	Marital Status (Circle One) Single / Married / Divorced / other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

What is exact name of insurance?	

What is the authorization number?	❑ Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Please answer the following questions that may be relevant to therapy:

1. Do you have any medical conditions being treated by a physician?
____yes ____no
If yes, please note condition and dates of treatment:

2. Are you currently taking medication? ____yes ____no
If yes, please specify type and dosage:

3. Have you previously attended therapy sessions? ____yes _____no
If yes, when? And for how long?

4. Do you have any history of suicidal ideation or suicide attempt?
____yes ____no If yes, please explain.

5. Are you currently experiencing overwhelming sadness, grief or depression?
____yes ____no
If yes, please describe and for how long.

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
____yes ____no If yes, please describe and for how long.

7. How often do you drink alcohol/week (including beer and wine)?

8. How often do you engage in recreational drug use?

9. What significant life changes or stressful events have you experienced recently?

10.What else would you like me to know about you?