# Kristina Monroe, Psy.D.

Licensed Psychologist

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## Confidential Client Information

***Contact Information***

Date: _____

Name: _____

Birth Date: _____ Age: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email:_____

*Please note that electronic communication is not guaranteed confidential. Dr. Monroe utilizes Hushmail and Spruce for secure communication with clients. Please provide a password below if you would like any email (other than scheduling) to be encrypted. Please check 'yes' below if you would like to receive an invitation to download the Spruce app, which allows for encrypted messaging (instead of SMS).*

What method is best for communication with you? ☐ Phone ☐ Text ☐ Email

Is it okay to leave a voicemail for you? ☐ Yes ☐ No

Is it okay to send a text message to you? ☐ Yes ☐ No

Do you want to receive an invitation for Spruce, the secure messaging app Dr. Monroe utilizes? ☐ Yes ☐ No

Is it okay to contact you via email? ☐ Yes ☐ No

Please provide a password that only you and Dr. Monroe will know for encrypted email (for anything other than scheduling): _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Do you consent to Dr. Monroe contacting the abovementioned person in the case of emergency? ☐ Yes ☐ No

Please sign here for consent: _____


***Demographic Information***

Sex: ☐ Female ☐ Male ☐ FTM ☐ MTF ☐ Intersex

Gender: _____

Sexual Orientation: _____

Race/Ethnicity:_____

Relationship/marital status: _____

Occupation: _____ Highest Education Completed: _____

***Referral Information***

Current reason(s) for seeking therapy: _____

_____

_____

_____

Estimate the severity of the problem for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

How many sessions or how much time do you think you need to successfully resolve this problem?

☐ 1 – 10 sessions
☐ 10 – 20 sessions
☐ 20 or more sessions
☐ Ongoing, longer-term therapy

How did you learn about Dr. Monroe's practice? _____

Referred by: _____

KM

***Health Information***

Please list medications you take as well as dosages and indication:

1._____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Psychiatrist (if applicable): _____ Phone: _____

Have you been hospitalized for psychological reasons or drug dependency? ☐ Yes ☐ No

If yes, please briefly describe: _____

_____

Have you previously been in psychotherapy? If so, when and for what reason(s)? Was it helpful or not?

_____

_____

_____

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems.)

_____

_____

_____

Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much? Has it ever affected your work or your relationships?

_____

_____

_____

KM

Please list any past/present medical issues/concerns (e.g. head injuries, thyroid issues, hospitalizations).

_____

_____

_____

Is there a history of mental health diagnoses in your family? If so, which diagnoses?

_____

_____

_____

Were there any issues with your mother's pregnancy and/or your birth that you are aware of? Any notable delays in developmental milestones?

_____

_____

_____

***Insurance Information***

Name of Insured: _____ Relationship to Insured: _____

ID Number: _____ Group Number: _____ Plan Name:_____

Employer/School: _____

If a Dependent, Insured's DOB: _____

Insured's Address: _____

_____

Insured's Phone Number: _____