

# Kristina Monroe, Psy.D.

Licensed Psychologist

CA: PSY24929 | NY: 019303



8235 Santa Monica Blvd., Ste. 303 • West Hollywood, CA 90046  
323-546-7792 • drmonroe@kristinamonroe.com • www.kristinamonroe.com

## Confidential Client Information

### Contact Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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 for Hushmail (encrypted email): \_\_\_\_\_

Lyra members only: Lyra Health collects outcome measures for your sessions and will send you an email on Dr. Monroe's behalf that will contain information about Lyra's services, including your sessions, and periodically ask several questions about progress towards your goals. Do you consent to Dr. Monroe sharing your email address with Lyra Health to collect feedback about your sessions?  Yes  No

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Sign here for consent: \_\_\_\_\_ Date: \_\_\_\_\_



**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: \_\_\_\_\_



**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?



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

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

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

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***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: \_\_\_\_\_

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Insured's Phone Number: \_\_\_\_\_