Comprehensive Mental Health
13341 US 290 BLDG 1-103, Austin Texas 78737
contact@comp-mh.com

Client Information

Full Legal Name: _____

Preferred Name/Nickname: _____

Date of Birth: _____ Sex: _____ SSN: _____

Cell: _____ circle if ok to: call text leave voicemail

Email: _____

Address: _____

Race & Ethnicity: _____ Pronouns: _____

Gender Identity: _____ Sexual Orientation: _____

Insurance Information

Insurance Company: _____ Insurance ID: _____

Group ID: _____ Pharmacy Name & Location: _____

Therapist name (if applicable): _____

Psychiatrist name (if applicable): _____

PCP name (if applicable): _____

Next of Kin/Emergency Contact Information

Name: _____

Relation: _____ Phone Number: _____

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PRESENTING CONCERNS: please briefly describe the reason(s) you're seeking therapy and/or psychiatry

_____
_____
_____
_____

What symptoms or challenges are you currently experiencing? (Check all that apply.):

☐ Anxiety ☐ Depression ☐ Trauma ☐ Grief ☐ Stress

☐ Relationship Issues ☐ Work/School Issues ☐ Anger ☐ Sleep Issues

☐ Other: _____

Mental Health & Medical History

Have you had previous therapy or counseling? ☐ Yes ☐ No

If yes, when and for what concerns? _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

1. _____
2. _____
3. _____
4. _____

Do you have any current or past mental health diagnoses? ☐ Yes ☐ No

If yes, please specify: _____

Do you have any current medical conditions? ☐ Yes ☐ No

If yes, please list: _____

Goals for Therapy: What are your goals or hopes for therapy?

_____
_____
_____

How'd you hear about us?

_____