PERSONAL INFORMATION

Legal Name: _____ Date of Birth: _____
LAST FIRST MIDDLE INITIAL

Preferred Name: _____ Age: _____ Gender: _____

Address: _____ _____ _____ _____
STREET APT/SUITE # CITY STATE ZIP

Primary Phone: _____ Alt. Phone:_____

Can we leave a message at this number? ☐Yes ☐No ***Can we leave a message at this number?*** ☐Yes ☐No

Emergency Contact: _____ Relationship to you: _____

Emergency Contact Phone: _____ Alt. Phone: _____

Do you have Children? ☐ Yes ☐ No Age(s) _____

Do they live with you? ☐ Yes ☐ No ☐ Part-time

How many people reside in your household? _____ Who? _____

What is your highest education level:
☐Elementary ☐Middle School ☐High School ☐Associates ☐Bachelors ☐Masters ☐Doctorate
☐OTHER_____

Check the appropriate box in ***each line:***

1.) ☐MINOR ☐UNDER GUARDIANSHIP ☐YOUR OWN GUARDIAN ☐OTHER
2.) ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED ☐OTHER
3.) ☐EMPLOYED* ☐ATTENDING SCHOOL ☐DISABLED ☐OTHER

*If employed, please list your place of employment _____

Use this space to explain any boxes checked "OTHER"_____

INSURANCE INFORMATION

Name of person responsible for charges incurred on this account:_____
This person will be responsible for any remaining balances not paid by insurance including, but not limited to: deductibles, copays, coinsurances

Who should be billed for services? ☐Insurance ☐Patient ☐Other

PRIMARY INSURANCE INFO

1. Insurance Company: _____
2. Name of Insured (policyholder):
_____
3. Policy Holder's Employer:_____
4. Member ID: _____
5. Group Number: _____
6. Effective Date: _____
7. ☐ I am the policy holder **(you may skip items 7-10)**
   ☐ I am **NOT** the policyholder
8. Relationship to Insured: ☐Child ☐Spouse
   ☐Other: _____
9. Policyholders Date of Birth: _____
10. Policyholder Address: (if different than patient)
_____

SECONDARY INSURANCE INFO

1. Insurance Company: _____
2. Name of Insured (policyholder):
_____
3. Policy Holder's Employer:_____
4. Member ID: _____
5. Group Number: _____
6. Effective Date: _____
7. ☐ I am the policy holder **(you may skip items 7-10)**
   ☐ I am **NOT** the policyholder
8. Relationship to Insured: ☐Child ☐Spouse
   ☐Other: _____
9. Policyholders Date of Birth: _____
10. Policyholder Address: (if different than patient)
_____

MEDICAL AND PSYCHOLOGICAL HISTORY

PHYSICAL SYMPTOMS: Check any symptoms you are ***currently have*** or have had in the ***past year***

- ☐ asthma
- ☐ unusual bleeding or bruising
- ☐ breathing problems
- ☐ headache
- ☐ chest pains
- ☐ constipation
- ☐ diarrhea
- ☐ dizziness
- ☐ fevers
- ☐ hearing problems
- ☐ high blood pressure
- ☐ tics
- ☐ irregular heart beat
- ☐ joint pain
- ☐ muscle pain
- ☐ numbness
- ☐ passing out
- ☐ seizures
- ☐ stomach pains
- ☐ visual changes
- ☐ weakness

PSYCHOLOGICAL SYMPTOMS: Check any symptoms you are ***currently have*** or have had in the ***past year***

- ☐ anger
- ☐ anxiety
- ☐ stress
- ☐ compulsive behavior
- ☐ depression
- ☐ disorganization
- ☐ eating problems
- ☐ aggression- towards people
- ☐ fears and phobias
- ☐ flashbacks
- ☐ perfectionism
- ☐ irritability
- ☐ learning challenges
- ☐ moodiness
- ☐ negativity
- ☐ aggressive behavior- towards objects (throwing things, etc)
- ☐ obsessive thinking
- ☐ procrastination
- ☐ panic
- ☐ memory challenges
- ☐ seasonal mood changes
- ☐ worry
- ☐ frustration

PAST DIAGNOSES: Check any that **have been suggested to you** by a mental health or medical professional (even if later ruled out or you feel the diagnoses are/were incorrect):

- ☐ depression
- ☐ sleep disorder (sleep apnea, etc.)
- ☐ thyroid condition
- ☐ vitamin D deficiency
- ☐ anxiety
- ☐ learning disability
- ☐ head injury (concussion, etc.)
- ☐ personality disorder
- ☐ bipolar disorder
- ☐ substance addiction
- ☐ iron deficiency
- ☐ anemia (any type)

CURRENT MEDICATIONS: Please include prescriptions from other doctors, vitamins/supplements, pain medication, methadone/suboxone treatment and any other substance you use that may potentially interfere with treatment.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(Use back of sheet if extra space is needed)

FAMILY HISTORY: Please check any condition present (*or suspected*) in a ***blood relative***:

- ☐ alcoholism
- ☐ other drug abuse
- ☐ other addictions
- ☐ eating disorder
- ☐ obsessive compulsive disorder
- ☐ abuse/ neglect
- ☐ trauma
- ☐ domestic violence
- ☐ bipolar disorder
- ☐ anxiety
- ☐ psychosis
- ☐ depression
- ☐ learning disorders
- ☐ in-patient treatment for mental health
- ☐ ADD/ADHD
- ☐ suicide attempts
- ☐ suicide(s)-successful
- ☐ sleep disorders

TREATMENT HISTORY

Who is your Primary Care Physician: _____ Clinic:_____

Pharmacy Name:_____ Pharmacy Location:_____

Have you had surgery within the past 2 years? ☐ Yes ☐ No Type of Operation_____

Do you have any serious illness(s) or injury? (Including self-harm) ☐Yes ☐No Please Explain: _____

_____

Have you received psychotherapy (therapy/counseling) services in the past? ☐Yes ☐No

Where? _____ From who? _____
WHAT AGENCY? NAME OF PROVIDER(S)

Was it helpful? ☐Yes ☐No Please Explain: _____

_____

Age of first experience with counseling or therapy: _____

Have you received psychiatric treatment (prescription medication) services in the past? ☐Yes ☐No

Who was your most recent **PSYCHIATRIC** prescriber? _____

Clinic name: _____ Clinic Phone: _____

Address: _____ _____ _____ _____
STREET APT/SUITE # CITY STATE ZIP

Was your treatment helpful? ☐Yes ☐No Please Explain: _____

_____

SUBSTANCE USE HISTORY

Do you use Caffeine? ☐ Yes ☐ No

If yes, how many servings/day? (Serving = 1 reg. cup of coffee, *can* of soda, etc.)

_____

Do you use Tobacco? ☐ Yes ☐ No If yes, how much? _____

☐ Trying to quit ☐ Quit How long ago? _____

Do you use Alcohol? ☐ Yes ☐ No

If yes, how many servings (Single beer, glass of wine, shot of hard liquor, etc.) do usually have when you drink alcohol? ☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6-7 ☐ 8+

How often do you drink? (i.e., daily, twice/ wk, once/ mo, etc.)

_____

ABUSE HISTORY

Have you ever been abused? ☐Yes ☐No Are you currently being abused? ☐Yes ☐No

Was the abuse: ☐Physical ☐Sexual ☐Emotional ☐Verbal ☐Other

HOSPITAL TREATMENT

Have you ever been hospitalized for psychiatric reasons? ☐Yes ☐No

If yes, when was most recent psychiatric hospitalization? _____

Approximately how many times have you been hospitalized for psychiatric reasons?

☐1-3 ☐4-7 ☐7-15 ☐15 or more

Age of first psychiatric hospitalization: _____

Please share any other relevant personal information that you think might be helpful for your mental health professional to be aware of: _____

_____

_____

AUTHORIZATIONS

Insurance Assignment and Release

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my health history. I understand it is my responsibility to keep my information accurate and up to date and will notify the office of any changes in health, insurance or contact information. I will not hold Marriage and Family Solutions, LLC (MFS) responsible for errors or omissions that I may have made in completing this form. Staff members and providers of MFS have my permission to contact the person I have listed as my emergency contact above. Staff can identify themselves as calling from MFS but without additional consent cannot discuss details of my treatment with this individual. I hereby authorize payment directly to my health care provider for all insurance benefits otherwise payable to me for services rendered. I authorize the providers of the office of MFS to release the information required to secure the payment of benefits. I authorize this use of this signature on all insurance submissions.

Signature: _____ Date: _____

If signed by someone other than patient: *(If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to, and acknowledgment obtained from the personal representative.)*

Print Name: _____ Role: _____
(Parent, legal guardian, etc.)