Garwood Counseling

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Client Information Form

The information contained herein is a patient medical record.
Disclosure or transfer without your authorization is expressly prohibited by law..

Circle Therapist You are Seeing: *Gail Garwood, LMHC*

Today's Date: ____/_______/______

◒About You (The Client):

The Client this information pertains to is: ***An Adult*** ***A Minor***

Your name: ______________________________ Date of Birth: ____/_____/_____ Age: _____

Home Street Address: ______________________________ Apt# ______

City: ______________________ State: ______________ Zip: __________

Home Phone: _____________ Work Phone: _____________ Cell: _____________

Number you prefer to be contacted: ________________ May I call you at work? **Yes** **No**

Best times to reach you at your preferred number: ________________

May I contact you via email? **Yes** **No** May I contact you via text? **Yes** **No**

You may opt out at anytime; your address/phone is never sold or shared with anyone

Email Address: ________________

Are you being seen **with** your partner as a **couple?** **Yes** **No**

◒You and Your Partner:

Partner's Name: ______________________ Date of Birth: ___/___/___ Age: ____

Home Phone: _____________ Work Phone: _____________ Cell: _____________

Number he/she prefers to be contacted: ________________ May I call him/her at work? **Yes** **No**

Best times to reach him/her at his/her preferred number: ________________

Are you married? **Yes** **No** Married or not, how long have you been together? ____________

Are you divorced/separated? **Yes** **No** If yes, for how long? ____________

Have you ever been separated from your current partner? **Yes** **No** If yes, how long? _________. When? _________.

◒Person to Call in Case of Emergency:

Name: ______________________________ Phone: ____________________.

Relation: ______________________________

◒Referral: How did you hear about my practice? (Circle as many that apply)

Friend **On the Internet** **My Insurance Co** **EAP Provider** **Other** ____________________

If a friend referred you, how did this person explain how I might be of help to you?

____.

If on the Internet, which site? ______________________________.

If through your Insurance Company, which company? ______________________________.

Will you be using your insurance to pay for my services? **Yes** **No** (If "No" skip the next section)

◒Insurance Information:

Please be certain to bring your Insurance Card to your first appointment

Are you the ***Primary Insured*** on the Policy? **Yes** **No**

The following pertains to the Person who is the Primary Insured on the policy:

Name of the ***Primary Insured*** (if not you): ______________________.

If not you, the ***Primary Insured's*** Date of Birth: ___/___/___.

Insurance ID Number: ____________________. Group: ____________________.

◒Your Medical Care:

Doctor's Name: ____________________. Phone: ____________________.

Address: ____.

If necessary, may I inform your doctor that you are in treatment with me so that he/she can be fully informed and we can coordinate your care? **Yes** **No**

◒Medical History:

Please describe any present or past major medical problems (e.g., major illness, surgeries, accidents, etc.):

____

____

◒Medications

Are you currently taking any psychotropic (e.g., anti-depressant/ anti-anxiety, etc.) medication(s)? **Yes** **No**

If yes, what is prescribed? ____

Dosage: ______________________ Who is the prescriber? **PCP** **Psychiatrist**

Are you presently taking any medications for physical (non psychiatric) problems? **Yes** **No**

If yes, what is prescribed? ____

Dosage: ______________________ Who is the prescriber? **PCP** **Specialist**

◒Alcohol & Drug Use:

How often do you drink an alcoholic beverage?

Never **Monthly** **2-4 times per month** **2-3 times per week** **More than 4 times per week**

On a day you do drink, how many alcoholic beverages might you have?

1 to 2 **3 to 4** **5 to 6** **More than 6** **More than 10**

In the past year, what is the greatest number of drinks you had on any one occasion?

1 to 2 **3 to 4** **5 to 6** **More than 6** **More than 10**

Have you ever wanted to stop drinking? **Yes** **No** If yes, have you and for how long?________________

Have loved ones expressed concern about your drinking? **Yes** **No** If yes, who? ________________

Have you ever had any legal problems due to your drinking (e.g., DUI)? **Yes** **No** If yes, when? __________

Have you ever had treatment for your drinking? **Yes** **No** If yes, what kind? **Inpatient** **Outpatient** **12 Step**

Are you currently using any street drugs (Marijuana, Cocaine, Methamphetamine, etc.)? **Yes** **No**

What drug(s) are you currently using? ______________________________________

How often? __________________________ How long have you used? ________________

Have you ever wanted to stop using? **Yes** **No** If yes, have you and for how long?________________

◒Your Education/Occupation:

Highest grade: ______________________ Degree: ______________________

Employer: ______________________ Position: ______________________

◒Prior Therapy:

Have you seen a Therapist before? **Yes** **No** Have you been in therapy more than once? **Yes** **No**

If yes to either, when? ______________________________ For how long? ______________________________

Reason(s) you sought therapy before: ____

Is this the same reason(s) you are coming to see me today? **Yes** **No**

Were you satisfied with the outcome of you previous therapy? **Yes** **No**

If yes, why: ____

If no, why not? ____

◒Your Significant Relationships:

Do you have any children? **Yes** **No** If yes, indicate below: (Use back or additional sheet, if necessary)

Name: ____ Gender: ____________ Age:__________

Name: ____ Gender: ____________ Age:__________

Name: ____ Gender: ____________ Age:__________

Are there other Family members living with you (elderly parents, siblings, etc)? **Yes** **No**

Name: ________________________________ Gender: ____________ Age:__________ Relation: ___________

Name: ________________________________ Gender: ____________ Age:__________ Relation: ___________

Briefly describe how well you get along with your partner or spouse: ____________________________________

____

What you MOST appreciate about your partner: ____

What your Partner MOST appreciates about you: ____

Major Life stressors (financial, employment, etc.) facing you, your partner and/or family? **Yes** **No**

If yes, briefly describe: ____

◒Your Family of Origin:

Are your parents still together? **Yes** **No** If yes, how long? __________________

Briefly describe the reason your parents are no longer together: ____

Do you have brothers and/or sisters? **Yes** **No**

Beginning with your oldest sibling (even if that's you), list their names and current ages: ______________________

____

If your parent(s) are still living, briefly characterize your current relationship with each of them: ______________

____

Is there a history of drug or alcohol abuse in your family of origin? **Yes** **No** If yes, who? ________________

◒Your Chief Concern:

Please describe the main difficulty that has brought you in to see me: ______________________________

____

____

Estimate the severity of the problem: **Mild** **Moderate** **Severe** **Very Severe**

◒Your Goals:

What would you MOST like to see happen in your life as a result of coming to see me? ____________________

____

What do you MOST want to change about yourself?

____

____

What do think or feel is the greatest barrier to creating change in your life right now? ____________________

____

◒And Finally . . .

Tell me anything more you would like me to know about you and/or the reasons you have come to see me today that you think would be essential that I know: ____

____

____

◒ Sign up for Our Email List:

We maintain contact with current and former clients through our email list. It is used for announcements and when a new post is published on Gail's Blog. We will be sending out emails which you can opt out of at any time. We respect your time and inbox space as much as we like to keep in touch. So, if you would like to sign on, add your email address below. Once you are added to the list, you will receive an email asking you to confirm your choice. Thank you!

Name: ____

Email Address: ____

Name: ____

Email Address: ____