Please complete all sections as accurately as possible. This information is confidential and protected under HIPAA. Fields marked for interna

Client Information

Legal First Name | Middle Initial | Legal Last Name | Preferred Name

Date of Birth (MM/DD/YYYY) | Gender Identity | Pronouns | Marital Status

Street Address | Apt / Unit | ZIP Code

City | State | Home / Cell Phone

Alternate Phone | Email Address | Preferred Contact Method

OK to leave a voicemail / send appointment reminders?

☐ Phone call ☐ Text message ☐ Email

Occupation | Employer

Emergency Contact

Emergency Contact Name | Relationship to Client | Phone Number

Insurance & Billing

Insurance Carrier | Member / Policy ID | Group Number

Subscriber Name (if not self) | Subscriber DOB | Relationship to Subscriber

Secondary Insurance (if any) | Secondary Member ID

For office / AdvancedMD use only:

AdvancedMD Patient ID | Eligibility Verified (staff initials) | Date Verified

How Did You Hear About Us?

☐ Physician referral ☐ Friend / family referral ☐ Insurance directory

☐ Online search ☐ Social media ☐ Employee Assistance Program (EAP)

☐ Other

Referred By (name, if applicable)

Reason for Seeking Services

Briefly describe what brings you to therapy at this time:

Please check any that currently apply:

- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Relationship / family issues
- ☐ Grief or loss
- ☐ Trauma / PTSD
- ☐ Anger management
- ☐ Sleep difficulties
- ☐ Substance use
- ☐ Work / school stress
- ☐ Life transition
- ☐ Other

How long have you been experiencing this? (check one)

☐ < 1 month ☐ 1-6 months ☐ 6-12 months ☐ 1+ years

Current severity (self-rated): (check one)

☐ Mild ☐ Moderate ☐ Severe

Goals for therapy

Mental Health History

Have you previously received mental health treatment or therapy? ☐ Yes ☐ No

If yes, with whom / when

Have you ever been psychiatrically hospitalized? ☐ Yes ☐ No

If yes, please explain

Are you currently taking medication for a mental health condition? ☐ Yes ☐ No

Medication name(s) and dosage

Is there a family history of mental illness or substance use? ☐ Yes ☐ No

If yes, please describe

Medical History

Primary Care Physician

PCP Phone Number

Current medications (all, including non-psychiatric) and dosages:

Allergies (medication, food, environmental):

Current medical conditions / diagnoses:

Substance Use

Alcohol use: (check one) ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily

Tobacco / nicotine use: (check one) ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily

Recreational drug use: (check one) ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily

If applicable, please specify substance(s)

Safety Screening

Your safety is our top priority. Please answer honestly — these responses are confidential.

Are you currently having thoughts of harming yourself or suicide? ☐ Yes ☐ No

Have you ever attempted suicide or self-harm in the past? ☐ Yes ☐ No

Are you currently having thoughts of harming someone else? ☐ Yes ☐ No

If you answered yes to any question above, please provide details (a clinician will follow up):

_____

Consent & Authorization

☐ I consent to receive mental health treatment from this practice.

☐ I acknowledge receipt of the Notice of Privacy Practices (HIPAA).

☐ I have reviewed and agree to the practice's financial / cancellation policy.

☐ I authorize this practice to bill my insurance carrier and/or communicate with them regarding my treatment as needed for billing purposes.

Client / Guardian Signature _____ Date _____

Printed Name _____ Relationship to Client (if signing on behalf of minor) _____