**New Client Information**

All information received here, and in the initial intake session is considered confidential regardless of subsequent contract for therapy services. If you have questions or concerns, please speak to your therapist prior to filling this out.

*Please clearly print the following requested information.*

Therapist You Are Seeing: Anna (Dianne) Beard, MA LPC. Today’s Date:

Client:

{Last} {First} {Middle Initial}

Birth Date (DOB): Gender: 🞎 Male 🞎 Female

Social Security Number: - - (required by some insurance plans)

Address:

City: State: Zip Code:

**Contact Information**

Home Phone: ( ) - Leave Message? 🞎 Yes 🞎 No

Work Phone: ( ) - Leave Message? 🞎 Yes 🞎 No

Cell Phone: ( ) - Leave Message? 🞎 Yes 🞎 No

Email:

Which of the above do you prefer to be contacted at first?

Would you like to receive text message reminders 1 day before your appointments? 🞎 Yes 🞎 No

Would you like access to the Client Portal to schedule your sessions online? 🞎 Yes 🞎 No

*(Requires a valid email address. You will be sent a link by email to setup your log-in information so you can schedule appointments and message me confidentially online if you desire.)*

Emergency Contact Name: Relationship:

Emergency Contact Number: ( ) -

**Personal Information**

Employed? 🞎 Yes 🞎 No

Employer:

Occupation:

Student? 🞎 Yes 🞎 No School:

Education Level Completed: 🞎 GED 🞎 High School 🞎 College 🞎 Graduate School

Relationship Status: 🞎 Single 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed 🞎 Significant Other

Spouse/Partner Name: DOB:

Spouse/Partner Employer:

Children? 🞎 Yes 🞎 No If yes, ages:

**Therapy Information**

Please explain why you feel a need for therapy

Areas of Concern: (Mark all that apply.)

|  |  |
| --- | --- |
| * Depression | * Relationship / Marriage |
| * Anxiety | * Children |
| * Anger | * Academic Concerns |
| * Grief | * Job Concerns |
| * Life Change | * Sexual Concerns |
| * Substance / Alcohol Use | * Abuse / Trauma History |
| * Spiritual Concerns | * Other: |

Please explain what you hope to gain from therapy

Previous Psychological Treatment? 🞎 Yes 🞎 No If Yes, please explain:

**Medical Information**

Primary Care Physician:

Clinic Name/Address:

Most Recent Medical Exam: ­­­­­­­­­­­­­­­­­­­­­­­­ History of Serious Illness? 🞎 Yes 🞎 No

If Yes, Explain:

Family History of Serious Illness? 🞎 Yes 🞎 No If Yes, Explain:

Please list all current medications you are on:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Reason Taking** | **Dose (mg)** | **Frequency** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Referred By**

|  |  |  |
| --- | --- | --- |
|  | Physician |  |
|  | Agency |  |
|  | Pastor / Church |  |
|  | Family |  |
|  | Friend |  |
|  | Former Client |  |
|  | Internet Search |  |
|  | Advertisement |  |
|  | Other (Please Specify) |  |