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Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Patient Information

Name: _____ Age: _____ Date of Birth _____
Home:_____ Cell _____ E-mail _____
May we email or txt you? □Yes □No May we leave a phone message? □Yes □No
*Please note: Email/txt correspondence is not considered to be a confidential medium of communication.
Home address:_____
Street City State Zip
Employer: _____ Address:_____ Phone _____
Position/Title _____ Social Security Number _____

Partner/Spouse

Name:_____ Age_____ Date of Birth_____
Home:_____ Cell _____ E-mail _____
Home address:_____
Street City State Zip
Employer: _____ Address:_____ Phone _____
Position/Title _____ Social Security Number _____
Children & Ages _____

Insurance: _____ Policy _____ Phone # _____
Referred By: _____ Religious Affliation: _____

Please state in your own words reasons for seeking services:
_____
_____

HEALTH INSURANCE CLAIMS: Patienct's or authorized person's signature is required to bill your insurance.
I authorize the release of any medical or other information necessary to process claims for services provided. I also authorize payment of medical benefits to Ann Landers,MFT for services provided.

_____ _____
Signature Date

Please provide the names and ages of the children in your family/household.

_____
_____
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes
□ No

Please list:

_____

_____

Have you ever been prescribed psychiatric medication?

□ Yes
□ No

Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

6. What is the most important thing you think "this Therapist" should know about your concerns:

_____

_____