CLIENT INFORMATION – CONTACT INFORMATION FORM

Date: _____

Client Name: _____ **Gender:** _____ **Date of Birth:** _____

Client Address: _____

May we correspond by email? Y / N Email address: _____

Client Home Phone:_____**Daytime Phone:**_____**Cell Phone:**_____

OK to leave message? ◉ **Y** ○ **N** **Message?** ◉ **Y** ○ **N** **Message?** ◉ **Y** ○ **N**

Marital Status: ○ **Single** ○ **Married** ○ **Divorced** ○ **Domestic Partner** ○ **Widowed** ○ **Other**

Employment Status: ○ **Full Time** ○ **Part Time** ○ **Full Time Student** ○ **Part Time Student** ○ **Unemployed**

Client Social Security Number: _____

Person filling out form, if not client: _____ **Relationship to client:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

(Initial here) _____ *I understand that my therapist may contact the emergency contact listed here if it is determined that the client's safety may be at risk.*

Are you involved in any legal proceedings (e.g. child custody dispute, divorce proceedings, etc) which may involve your therapist?
○ *Yes* ○ *No* *(Circle one)* *If yes, please describe:*

How did you hear about Northwest Relationships, or who referred you to us? (Include phone number/email address of referring source)

621 Pacific Avenue, Suite 300, Tacoma, WA 98402 Phone: (253) 292-1216 Fax: (206) 299-3272
E-Mail: info@northwestrelationships.com Web: www.northwestrelationships.com

INSURANCE INFORMATION - Please fill out all of the following information even if a copy of your insurance card is attached

Primary Insurance: _____ **Insurance Company Phone:** _____

Authorization Number: _____ **Policy Holder SSN:** _____

Insurance Billing Address: _____

Name of Primary Policy Holder Exactly as It Appears on the Card: _____ **Date of Birth:** _____

Policy Holder I.D. #: _____**Group #:** _____ **Group Name:** _____

Policy Holder Mailing Address (if different from client's): _____

Policy Holder Phone: _____ **Relationship to Client:** _____

My signature below authorizes Northwest Relationships to bill and release all necessary information to the insurance company noted above. I authorize this signature on all insurance submissions. I also agree to the payment agreement.

If I am paying for services out of pocket, I authorize Northwest Relationships to bill me directly for services.

_____ _____ _____

Responsible Party Signature | Relationship to Client | Date

SAVED PAYMENT INFORMATION - Please sign the following line if you would like to have NWR save your credit card electronically for future payments.

I,_____, authorize_____to charge my credit card for agreed upon therapy services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature | Date

APPOINTMENT REMINDERS/ELECTRONIC CONTACT CONSENT

Northwest Relationships offers free of charge e-mail/text/or phone appointment reminders. If you would like to receive e-mail/phone/text appointment reminders, please read and sign below.

I understand that if Northwest Relationships fails to remind me of an appointment, I am still responsible for the late cancellation or no-show fee agreed to at intake.

I understand that Northwest Relationships uses a secure e-mail server to send and receive e-mails from clients. I understand that I am solely responsible for the security of e-mails that I send/receive and that Northwest Relationships is not responsible for a breech of privacy, confidentiality, or security for e-mails that I send/receive. The e-mail system is solely used for appointment reminders.

I wish to receive reminders via (select one):

☐ Phone/Text: Preferred #: _____

☐ Email: Preferred Email: _____

_____ _____

Signature | Date

NORTHWEST RELATIONSHIPS

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy (see attached office policies). Use the back of form as necessary.

1) Briefly describe what has happened recently that led you to seek counseling now.

2) Please check any of the concerns or symptoms listed below that you are currently experiencing:

- ☐ marriage/relationship problems
- ☐ difficulties with family
- ☐ difficulties with friends
- ☐ school problems
- ☐ step-family problems
- ☐ divorce issues
- ☐ serious physical illness (self or family)
- ☐ health concerns (self or family)
- ☐ fatigue/low energy
- ☐ death of family member or friend
- ☐ anxiety/worry/nervousness
- ☐ panic attacks
- ☐ reluctant to leave home or familiar neighborhood
- ☐ perfectionism
- ☐ guilt/shame feelings
- ☐ trouble sleeping
- ☐ depressed mood/sadness
- ☐ suicidal thoughts
- ☐ self-injury
- ☐ eating habits
- ☐ spending habits
- ☐ concerns about behavior/habits/compulsions
- ☐ concern about alcohol/drug use
- ☐ concern about lying or dishonesty with others
- ☐ anger/irritability
- ☐ mood swings
- ☐ loss of temper/outbursts
- ☐ aggressive/violent behaviors
- ☐ physical abuse of self (current or past)
- ☐ verbal/emotional abuse (current or past)
- ☐ loss of interest in previous activities
- ☐ recurrent flashbacks
- ☐ episodes of lost time, unexplainable actions
- ☐ trouble with memory or concentration
- ☐ confusion
- ☐ much fantasy or daydreaming
- ☐ hyperactivity/attention problems
- ☐ headaches/stomach aches
- ☐ sexual problems
- ☐ sexual identity concerns
- ☐ identity concerns
- ☐ feelings of unreality
- ☐ obsessive thoughts/excessive fears
- ☐ unusual thoughts or perceptions
- ☐ excessive energy
- ☐ impulsive decisions or actions
- ☐ difficulty trusting others
- ☐ low self-esteem
- ☐ avoidance of conflict
- ☐ withdrawn, isolating
- ☐ shy/uneasy around others
- ☐ fear of failure
- ☐ fear of disapproval
- ☐ need to please others and be liked
- ☐ difficulty saying "no" to others or asserting self
- ☐ difficulty making independent decisions
- ☐ feelings of futility/loss of hope
- ☐ loss of joy in living
- ☐ physical abuse of others
- ___ other _____

3) Check the response which best applies:

My current concerns and symptoms are:

- ☐ *The continuation of a long-standing condition*
- ☐ *A recent worsening of an on-going condition*
- ☐ *The reoccurrence of a previous condition*
- ☐ *Significantly different from any previous condition*
- ☐ *My first occurrence of any condition*

My current symptoms developed:

- ☐ *Suddenly (over less than 4 weeks)*
- ☐ *Gradually (over one to several months)*
- ☐ *Very gradually (over one to several years)*

4) Please rate the overall level of stress that you feel is currently pressing on you, including life changes, work, family, and finance. (Circle appropriate number)

◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
minimal		moderate		extreme

Comment:

5) Do you have thoughts about hurting yourself or others? YES ◯ NO ◯
Please describe.

6) Have you ever had thoughts about hurting yourself or others? YES ◯ NO ◯
Please describe.

7) Please list your goals for therapy.

-
-
-

Social History

What do you consider to be your:

- Gender:
- Ethnicity:
- Religion:
- Marital status:
- What else is important to how you identify as a person?

Please briefly describe your:

- Educational/occupational history

- Legal history (arrest history, sentencing, incarceration, litigation, etc.)

- Military involvement

Family Relationships

Spouse/Significant Other: _____ Age: _____

Children (Please list names and ages): _____

Parents (Please list names and ages): _____

Other important family members: _____

Briefly describe your current family situation and relationship history.

List any important events that have significantly impacted your life, including dates and people involved.

Briefly describe your current support system (family, friends, organizations, self):

In thinking about your network of friends, family, etc., how would you rate the amount of <u>helpful</u> social support currently available to you.

○ 1	○ 2	○ 3	○ 4	○ 5
none		some, but not adequate		adequate

Medical/Mental Health History

Please list major injuries, illnesses or surgeries.

Condition _____

Dates _____

Treatment_____

Current and past medications:

Medication _____

Dosage _____

Prescribing Physician _____

Date Started _____

Allergies/Sensitivities to medications _____

Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.)

Have you ever previously received a mental health diagnosis (e.g. depression, anxiety, bipolar, ADHD, OCD, etc)? If yes, what, when, and by whom?

Has anyone in your immediate or extended family had a mental health diagnosis (e.g. depression, anxiety, bipolar, ADHD, OCD, etc)? Please list relationship and nature of diagnoses?

Is your home cluttered? ○ *YES* ○ *NO*

Do you experience difficulty discarding or parting with your possessions? ○ *YES* ○ *NO*

Does clutter at home interfere with your family life, friendships, or ability to perform well at home or work, or to maintain a safe environment for yourself and others? ○ *YES* ○ *NO*

Please list other substances that you use. Include amount and frequency.

Alcohol _____

Marijuana _____

Caffeine _____

Tobacco (cigarettes, etc.) _____

Other _____

Does anyone in your family have a history of substance abuse? Please describe.