JILL SMITH + associates

COUNSELING • COACHING • CHANGE

Personal Information: **Date:**

Full Legal Name of Client:_____

Age: _____ DOB: _____ Marital Status: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Is it ok to contact you and leave messages at the numbers and email above? ☐ Yes ☐ No

Employer & position: _____

Who referred you for counseling? _____

Emergency Contact Person: _____ Phone #: _____

Doctor & Medicine

Family Physician Name: _____

Physician Phone and Group Name: _____

Psychiatrist Name (if app): _____

Psychiatrist Phone and Group Name: _____

Any health issues or concerns? _____

List all medicines you are currently taking:

_____ _____

_____ _____

_____ _____

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Mental Health History:

Previous counseling? ☐ Yes ☐ No
Name of Therapist: _____
Diagnosis: _____
Approximate date of treatment: _____

Hospitalizations? ☐ Yes ☐ No

Date(s): _____

Hospital(s): _____

Circumstances: _____

Have you ever attempted suicide? ☐ Yes ☐ No

Are you currently having any suicidal thoughts? ☐ Yes ☐ No

Is there a family history of mental health concerns? ☐ Yes ☐ No If yes, who?_____

What was the diagnosis? _____

Substance Use

Do you currently use any of the following substances?

Alcohol: ☐ Yes ☐ No If yes, how much? _____

Cigarettes: ☐ Yes ☐ No If yes, how much? _____

Other chemical substances (marijuana, cocaine, painkillers): ☐ Yes ☐ No If yes, how much? _____

Caffeine: ☐ Yes ☐ No If yes, how much? _____

Other: ☐ Yes ☐ No Describe use: _____

Is there a family history of substance abuse? ☐ Yes ☐ No If yes, please describe below:

_____

Sleep

How much sleep do you routinely get each night? _____
Trouble falling asleep or staying asleep? _____

Do you have any sexual concerns? ☐ Yes ☐ No
If yes, please describe: _____

Religion/Spirituality

Do you have a religious affiliation? ☐ Yes ☐ No
If yes, please describe: _____
How important is a spiritual perspective to you in doing therapy? _____

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Legal Concerns

Are there any legal issues that impact therapy? ☐ Yes ☐ No If yes, please describe: _____

_____

If Patient is a Minor

Mother's name: _____ Mother's phone #: _____

Father's name: _____ Father's phone #: _____

Are there any academic concerns? ☐ Yes ☐ No If yes, please describe: _____

_____

By my signature below I grant permission for my minor child to be seen in therapy at Jill Smith & Associates. Note: It is our policy to contact and involve both parents when working with a minor-particularly in families where the parents are divorced or do not reside together. A court order must be provided for any situation where a parent is not allowed communication or involvement.

_____ _____

Signature Date

Briefly describe why you have come and what you hope to gain from counseling:

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

By signing above I acknowledge that I have read, understand and agree to this office's:
Payment Policy Office Policies and Procedures Privacy Policy