Bonnie Rose, M.A., L.M.F.T.

License #32633

www.BonnieRose.com

Client Information

Name_______________________________________Today's Date_______________

Social Security No.___________________________Birthdate____________________

Address____

City_______________________________________State_________Zip____________

Home Phone_____________________May We Leave A Message? Yes__No__

Work Phone_____________________May We Leave A Message? Yes__No__

Mobile Phone_____________________May We Leave A Message? Yes__No__

Email Address__________________________May We Email You? Yes__No__

Please note: Email correspondence is not considered to be a confidential medium of communication

Insurance Co____

Policy No_________________________________Group No_______________________

Subscriber Name______________________________Birthdate_________________

Employer________________Relationship to Patient: Self____Spouse____Child____

InsCo Phone_______________________CoPay Amt On Insurance Card________

Name of Emergency Contact____

Best Phone Number__________________________Relationship__________________

Please provide any information that you want me to know about your health history.

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____

____

What is your main concern (s) that brings you to therapy?

____

____

____

Approximately how long has this concern (s) been bothering you?

*Day*_______*Week*_______*Month*_______*Several Months*_______

*Year*_______*Several Years*_______*Most of my Life*_______

Please indicate how your problems are affecting the following areas (circle):

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship						
Family						
Job/School Performance						
Friends						
Hobbies						
Financial Situation						
Physical Health						
Anxiety Level/Nerves						
Mood						
Sexual Functioning						
Ability to Concentrate						
Ability to Control Your Temper						
Spirituality						
Eating Habits						

If your eating habits are affected, describe how:

____

Sleeping_______________________________________

If your sleeping habits are affected, describe how:

____

HABITS	Amount Currently Using	Most Ever Used
Coffee (cups/day)	______________________	______________
Cigarettes (packs/day)	______________________	______________
Alcohol	______________________	______________

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment of any kind before? Y___N___

If you checked yes to the above question, please answer the following:

What type of care did you receive: Inpatient (hospital)___Outpatient___Both___

When were you in treatment?_____________Where were you in treatment?___________________

Did your doctor prescribe medicine at that time? Y___N____Not Applicable________________

If yes, what was prescribed? (include dosages if know)___________________________________

SUBSTANCE USE HISTORY:
Have you ever abused drugs or alcohol?
If yes, please describe: Substances Amount Frequency When? (First use; Last use)

Substances	Amount	Frequency	When? (First use; Last use)
______________________________	_________	__________	_________________________
______________________________	_________	__________	_________________________
______________________________	_________	__________	_________________________

If yes, have you ever received substance abuse treatment of any kind before? Y___N___
Do you have a history of blackouts, seizures or withdrawal symptoms? Y___N___

Employer / School:________________________ Job Title:___________________________
Marital Status: Never Married_______ Domestic Partnership_______
Married_______ Separated_______ Divorced_______ Widowed_______

Name of Family Members	*Age*	*Relationship to Client*	*Living at Home (Y or N)*

Please describe anything else you would like me to know:

____

____

Are you fearful of or allergic to : Dogs? Yes____ No____ Cats? Yes____ No____

Name & Phone No of the Person Who Referred You

____

I, ____________________________________, hereby give permission to Bonnie Rose to contact the person who referred me, for the sole purpose of thanking them for their referral. I acknowledge that this person will know I am receiving psychotherapy services from Bonnie Rose.
Signature____ Date______________________