jlp Marriage & Family Therapist

Date: _____

BACKGROUND INFORMATION

Last Name: _____ First Name: _____ MI: ____

Last 4 digits of SSN: _____ DOB: ___/___/___ Age: ____ Sex: ☐ M ☐F Ethn

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Address: _____ City: _____ State: ____ Zip: _____

Home Phone:_____ Cell Phone:_____

E-mail:_____

Preferred Method of Contact: ☐Cell Phone ☐Home Phone ☐Email

Check if can leave a message on: ☐ Home phone ☐ Cell Phone

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _____ First Name: _____ MI: ___

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Other Phone: _____ Relationship: _____

HEALTH CARE RESOURCES

☐ Private Insurance ☐Medicaid/SoonerCare ☐ None

Provider: _____ Policy/Medicaid Number: _____

Policy Holder (cite name as is appears on the insurance card): _____

Policy Holder Date of Birth _____

Other information:_____

CURRENT LIVING SITUATION & FAMILY HISTORY

_____

Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐Female

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐Female

Last Name: _____, First _____, MI ___ Age __ ☐e Ma ☐ Female

OTHERS LIVING IN HOME (use back if needed)

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

_____

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? _____

Please write a couple of sentences concerning the reason for your request of services.

_____

_____

_____

Please check your employment status □ Full-time □Part-Time □Unemployed □Not in Labor Force

If employed, who is your employer?

_____

What is the highest level of education you have received?_____

Have you served in the military? ____ If yes, current status? _____

Are you currently receiving any government assistance? ____ If yes, what programs? _____

Please check all that apply □ Medicaid □ Medicare □ SSI □ SSDI

Are you currently using tobacco products? ___ If yes, frequency of use? _____

How many days have you used tobacco in the past 30 days?_____

Are you currently using alcohol? ___ If yes, frequency of use?

Are you currently using other substances? ___ If yes, frequency of use?_____

How many times have you been in jail in the past 30 days?_____ 12 months?_____

Have you ever experienced (check all that apply): □ Physical Abuse, □ Emotional / Verbal Abuse, □ Sexual Abuse / Molestation / Sexual Misconduct, □ Neglect, □ I would rather not answer these

Have you ever attempted suicide? YES or NO

If "yes," identify month & year of attempt(s) _____

Have you ever had thoughts of suicide? YES or NO

If "yes," identify month & year of latest thought(s) _____

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐No

If yes, describe: _____

_____

Physician Name: _____ Phone: _____

Are you currently taking medications? ☐ Yes ☐No

If yes, list those you are currently taking (use back if needed):

Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
☐ _____	_____	_____	_____
☐ _____	_____	_____	_____
☐ _____	_____	_____	_____

Please list any allergies:_____

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No
If yes, provide the following:

Date		Where	Purpose/Diagnosis
_____	_____	_____	_____

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include any other information you feel is important for therapist to know.

_____

_____

_____

_____

Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

Where would you like to receive appointment reminders? (check one)

_____ Text message on my cell phone (normal text message rates will apply)

_____ Email message to the address listed above

_____ Automated telephone message to my home phone

_____ No Reminders.

Email address: _____

Cell phone number: _____

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Appointment reminders are automated. If you do not receive a reminder when you have a scheduled appointment, your appointment is still scheduled and missing session without canceling will result in No Show/Late Cancellation fee.

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Signature Date