CONFIDENTIAL CLIENT INFORMATION & INTAKE FORM

Please complete these forms for your first session.

Name: ______________________________ **Age:** ___ **Gender:** ________ **Birth Date:** ___/___/____

(Last) (First) (Middle Initial)

Mailing Address: ______________________________

(Street)

____

(City) (State) (ZIP)

Name of Parent/Guardian

(if under 18 yrs.): ______________________________

(Last) (First) (Middle Initial)

Contact Information	Cell Phone	Home Phone	Email (not considered confidential)
OK to Leave Message and/or Appointment Reminder?	( ) ____- ________ ☐ YES ☐ NO	( ) ____- ________ ☐ YES ☐ NO	☐ YES ☐ NO

Emergency Contact

Name:	Relationship:	Phone: OK to Leave Message? ☐ YES ☐ NO

1. I'm here: ☐ By choice ☐ Encouraged ☐ Forced
2. Are those close to you aware/supportive you're seeking counseling support?
   ☐ Yes ☐ No (please specify)
3. Reason(s) for seeking support:
4. Challenges/significant life events?
5. How do you support your mental health? I cope/manage stress by:
6. Important relationships (mark all that apply)

   I am currently : ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Dating

   years : _______ _______ _______ _______ _______ _______

   I have : ☐ Children #:____ ☐ Pets #:____ ☐ Friends #:____
7. Some of the people who are most important to me are: (name &/or relationship)
8. What best describes you? (select all that apply)

   ☐ Homemaker ☐ Work full time ☐ Part time ☐ Unemployed

   ☐ Retired ☐ Student ☐ Volunteer ☐ Other:____________

Interests, Hobbies	Last Education	Work, Occupation	Life Goals?

9. Do you enjoy your daily routine? ☐ Yes ☐ No (please specify)

   Sleep routine? ☐ can't sleep ☐ sleep too much ☐ sleep enough ☐ need more

   Diet routine? ☐ eat/drink whatever ☐ try eat/drink right ☐ good balance

   Physical activity routine? ☐ not at all ☐ try now and then ☐ have routine

   Besides sleep, diet, activity -how else do you support your physical health?

10. Current physical health concerns/goals:

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MEDICAL CARE INFORMATION	IF 'YES' PLEASE SPECIFY
1. Currently receiving medical treatment	☐ No ☐ Yes (specify)
2. Psychiatric medication?	☐ No ☐ Yes (specify)
3. Current prescription medication(s)	☐ No ☐ Yes (specify)
4. Supplements	☐ No ☐ Yes (specify)
5. Allergies	☐ No ☐ Yes (specify)
6. Name of Physician:	Phone:
7. Past hospitalization?	☐ No ☐ Yes (specify)
MENTAL HEALTH CARE INFORMATION	**SPECIFY, PLEASE INCLUDE APPROXIMATE DATES:**
8. Experience(d) traumatic event?	☐ No ☐ Yes (specify)
9. Experience(d) childhood trauma: abuse (ie. physical, sexual, psychological)	☐ No ☐ Yes (specify)
10. Experience(d) childhood trauma: neglect, hunger, separation/removal from home	☐ No ☐ Yes (specify)
11. Inconsistent, unreliable home support	☐ No ☐ Yes (specify)
12. Family substance abuse concerns (ie. drug, alcohol etc)	☐ No ☐ Yes (specify)
13. Experience(d) domestic violence	☐ No ☐ Yes (specify)
14. Experiencing overwhelming emotions, sadness, grief, anger, frustration or depression	☐ No ☐ Yes (specify)
15. Have you ever attempted suicide?	☐ No ☐ Yes (specify)
16. Have you ever contemplated suicide?	☐ No ☐ Occasionally ☐ Often
17. Anxiety, phobias, flashbacks and/or nightmares?	☐ No ☐ Yes (specify) how often: ☐ weekly ☐ monthly recent episode:
18. Those close to you express concerns regarding your work or family obligations?	☐ No ☐ Yes
19. Those close to you express concerns regarding your intake of drugs or alcohol?	☐ No ☐ Yes
20. Current, previous type of mental health services (ie. talk therapy, psychiatric services etc)	☐ No ☐ Yes (specify)
21. Current, previous support group, routines or programs.	☐ No ☐ Yes (specify)
22. Past therapist or treatment program	☐ No ☐ Yes (specify)
23. Outcome Helpful?	☐ No ☐ Yes (specify)
24. What else works for you?	

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Insurance Information

Who is responsible for the bill? ☐ Patient ☐ Insurance*

Primary Insurance Carrier: ____________________________________

Membership #: ____________________________________

Name of Subscriber: ____________________________________

Date of Birth of Subscriber: ____________________________________

Relationship to Subscriber: ____________________________________

Assignment and Release:

I hereby consent and authorize to have Christopher Gettman, of Christopher Gettman LMFT, LLC, to make any and all insurance claims on my/our behalf. I also authorize the therapist named above to release any information required to the insurance carrier. I understand that I am financially responsible for all charges whether covered by insurance or not.

Signature: ____________________________________ Date: ____________________________________

If authorization is provided by a personal representative of the patient, please describe relationship to patient/authority status to provide authorization: ____________________________________

For Office Use Only:

☐ Insurance Card Copied

☐ HIPAA Form Signed

☐ Under 18, parent consent form