Client Information Questionnaire Today's Date: _____

Legal name _____Preferred name: _____

Mailing Address: : _____

Physical Address: _____

Preferred phone 1. _____ 2. _____

Where may I leave a message? Circle appropriate: Phone #1 or Phone #2

Email: (for scheduling purposes only) _____

Age ____ Birth date _____Gender assigned at birth _____ Gender _____

Pronoun(s) used: _____ Orientation _____ Race/ethnicity _____

Marital status _____ Name of partner(s) _____

Who do you live with? _____ Are you safe at home? _____

Do you have children? (how many? gender? age?) _____

Who do you help take care of _____

Current Employment and current (or highest level) school Information (Name, position/grade)

_____

Briefly describe your reasons for seeking assistance (2-3 sentences, use back if needed)

Who suggested you contact me? _____

Are you interested in (circle all that apply) expressive arts therapy talk therapy

Expressive arts groups telehealth in person

What if anything have you tried before to address your concerns? Was it helpful? (continue on back)

When was your last physical exam? _____

Name/number of health care practitioner_____

*If your last physical was not within the last year, would you be willing to schedule an exam as soon as possible, to rule out any medical issues that may be impacting your mental health? **yes or no (circle one)**

If you do not have a primary care physician, would you like my assistance to find one **yes or no (circle)**

Do you have any severe allergies? If so, to what? _____
**Please note I sometimes have peanuts/peanut butter in my office. Please let me know if this poses a risk to you-or if there is something else that might. I prefer a fragrance free office because of my own allergies. Thank you for your consideration.*

Are you currently being treated for a mental health disorder by a doctor/apn? If yes, name and phone number
_____

List any health problems you are dealing with (acute or chronic) Use back if necessary:

_____

_____

List all current medications and past medications for any mental health issues (use back if needed)
_____

_____

Emergency Contacts (name, relationship and phone number):

_____

Please note that I am accepting only a limited number of insurances at this time. Please refer to the good faith estimate paperwork or my website to learn more about my out of network fees. If you are planning to use your insurance it is your responsibility to check your benefits before our first meeting. Please make a copy of your insurance card and return it with your paperwork. If your insurance is in someone else's name (partner, parent) I will need that person's name, birthdate and address.

_____

Is there anything else you would like me to know? (use back)

_____ _____
Signature Date