Adult Confidential Information Assessment

Name:_____Date of birth:_____
Phone Number:_____Is it OK to leave a voicemail?:_____
Address:_____City, State, Zip:_____
Emergency Contact Name :_____
Phone Number:_____Relationship:_____
Consent to Contact in Case of Emergency? If yes please sign_____
Marital Status:_____
Employment Status:_____Employer Name:_____
Primary Care Physician Name:_____
Primary Care Physician's Address :_____
_____
Primary Care Physician's Phone Number: _____
What brings you to counseling:_____
_____
_____
Any thoughts of harming yourself? _____
Any thoughts of harming someone else?_____
Any previous experiences with counseling?_____
Any experiences of abuse or neglect currently or in the past? (if yes please explain)
_____
_____
_____
Has any one in your family struggled with mental health or substance abuse
issues that you know about? (Examples: anxiety, depression, alcoholism, suicide)
_____
_____
_____
Any children or adults that are currently under your
care?:_____
Are your currently struggling with any legal issues?_____
Do you have any current or historical medical issues? If so please
list:_____
_____
_____
_____
Are you able to complete all activities of daily living and self care? If not please
explain._____
_____
List of current medications including
supplements:_____
_____
Do you currently use tobacco or caffeine? If yes how often and how much?:_____
_____
_____
Have you ever consumed alcoholic beverages? If yes how much and how often?
_____
Have you ever used drugs (Examples: marijuana, cocaine, LSD, heroin, ecstasy)? If so
how much and how often?_____

Please complete the following information if you are using insurance for services:

Insurance Carrier:_____
Plan Name:_____
Policy Number:_____
Subscriber's Name:_____Date of Birth:_____
Subscriber's Address:_____City, State, Zip:_____
Relationship to Subscriber:_____

I certify that I and/or my dependant(s) have benefits that are active through the above noted policy. I authorize Monira Philipp to share my protected health information with my insurance carrier for the purpose of obtaining coverage for my mental health care. I agree that I am financially responsible for any services or charges that are not covered by my insurance carrier. I authorize the use of my signature on claims to my insurance carrier. This authorization expires one year after termination of treatment.

_____ _____
Name Date