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5100 N. Brookline Ave., Suite 620
Oklahoma City, OK 73112-3609
(405) 226-8509

Date: _____

BACKGROUND INFORMATION

Last Name: _____ First Name: _____ MI: ____

DOB: ___/___/___ Age: ____ Sex: M F Ethnicity _____

Marital Status: (circle one) Single Married Separated Divorced Widowed

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail_____

Check if we can leave a message on your: (circle one) Home phone Work 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

(circle one) Private Insurance Public Insurance (Medicaid) None

Provider: _____ Policy/Medicaid Number: _____

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

Policy Holder Date of Birth _____

Policy Holder place of employment:_____

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (circle one): Alone w/Spouse, Partner, or Significant Other in Community Based Shelter

Other: _____ 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 __ Male Female

OTHERS LIVING IN HOME (use back if needed)

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

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

City & State _____ If minor, with whom _____

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

City & State _____ If minor, with whom _____

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: (circle one) 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 so what is your current status? _____

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

Please circle all that apply Medicaid Medicare SSI SSDI

Are you currently using alcohol? ___ If so, please describe your use. _____

Are you currently using other substances? ___ If so, please describe your use. _____

Have you ever experienced (circle 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: _____

Address: _____ City, State, Zip: _____

Are you currently taking medications? (circle one) 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? (circle one) Yes No

If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? (circle one) Yes No

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

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

How many self-help meetings have you attended in the past 30 days?_____

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

_____

_____

_____