Lynette Ingram Cassel, ATR, LMHC

Client Information

Date: _____

Identification

Client Full Name: _____

Client date of birth: _____ Age:_____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Best phone #: (home/cell?)_____ Ok to leave a message? _____

E-mail: _____

Name of emergency contact: _____Relationship to client: _____ Phone _____

If not client, your name and relationship: _____

How did you hear about Lynette? _____

**Statements referring to "you" mean the client, which may be your child if listed above.*

Health Insurance Information

Insurance Company: _____ Insurance Number: _____

Primary Insured? Y/N If not, who? _____ DOB _____

Behavioral/Mental Health Benefit Phone #: _____

Did you need an authorization for sessions?_____ Co-payment amt _____

Health Information

Please answer the following questions using: 5 . Excellent, 4 . Good, 3 . Average, 2 . Poor, 1 - Failing

How would you currently rate your physical health: _____ mental health: _____

Please list current symptoms (reason you are here) and circle those you currently find most bothersome:

_____

_____

_____

_____

From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Do you now have, or have you had in the past, any significant medical issue (ex. asthma, diabetes, high blood pressure, major surgery, digestive disorder, sleep disorder, miscarriage)? If so, please list here:

_____

Please list any current prescription medications/what medication is treating:

_____

_____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____

Do you use alcohol or drugs? _____ What/how often? _____

Are you currently receiving other mental health services? _____

Name of provider: _____Type of service_____

Phone number:_____

If you enter treatment with me, may I consult with your health provider(s) so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No (I will provide separate consent form).

Have you/your child been hospitalized for mental health purposes in the past?_____ When? _____

Have you participated in mental health or substance abuse treatment in the past? _____

Where/ When?_____

Was it helpful? _____

Have you/child felt like harming self or others recently or in the past? _____

Personal information

Religious and racial/ethnic identification _____

Current religious denomination/affiliation _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

If adult is client, what is your occupation?_____

Name of employer? _____

Your education and training

Highest degree completed/area of study _____

If child, what grade, and name/location of school? _____

Are there any educational accommodations or IEP in place? If yes, give details. _____

_____

Are you involved in any legal matters (ex,probation, custody)? _____

Family Information

With whom do you live currently? What is your relationship to them (spouse,parent, roommate, child, etc). Please list name and ages below:

_____

_____

_____

If adult is client, are you currently in a relationship? If so, name person, length of relationship and status.

_____

If adult is client, do you have children (including not living with you)? If not listed above, please list name/age here._____

Were you or child adopted: _____ If yes, age at time of adoption: _____

Domestic or international adoption (circle one). State or Country of birth _____

Are you/child in contact with birth family?_____ Type of contact _____

Were you/child ever in foster care or residential care: _____If yes, list dates and placement details:

_____

_____

Do you have siblings? If not listed above, please list name, age, and place of residence below:

_____

If adult is client, where did you grow up? _____

Parents names, age, and current relationship/contact with them: _____

_____

_____

Have you or anyone in your family ever been diagnosed with a mental illness? If yes, please list relation ship(s) and illness(es): _____

_____

Have you or anyone in your family ever experienced abuse/neglect/violence? If yes, please list whom and which experience_____

_____

Is there any other information you think I should know? _____

_____

_____

Thank you for sharing this information. I will go over it with you in more detail in our sessions. Please let me know if you have any questions. This information remains confidential, as outlined in the notice of privacy practices you received.