





**Insurance Information:** Please completely fill out if you are using insurance benefits and bring a photocopy of your insurance card, front and back, to your first session. Please also call your insurance company to find out all the following information prior to your first session. It is your responsibility to make sure you will be covered adequately at the time of service. If you do not have this information, you will be billed at the time of service.

Insurance Company: \_\_\_\_\_ Plan name: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Ins Tel: \_\_\_\_\_ Ins Fax: \_\_\_\_\_ MD referral necessary?: \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Are you the policy holder? \_\_\_\_\_ Relationship to policy holder \_\_\_\_\_

Do you have a deductible? \_\_\_\_\_ Deductible amount? \_\_\_\_\_ Deductible met for yr? \_\_\_\_\_

Copay amount: \_\_\_\_\_ Coinsurance amount: \_\_\_\_\_ # sessions/year \_\_\_\_\_

Prior authorization necessary?: \_\_\_\_\_ Authorization # \_\_\_\_\_

I give permission for CVL to bill my insurance company for psychological services rendered.

**Please sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Race: African-American/Black      Hispanic/Latino(a)      Native American      Asian  
Caucasian/White      Pacific Islander      Other: \_\_\_\_\_

\* Please indicate how you self-identify, as these categories may not best apply.

First language: \_\_\_\_\_ Other languages: \_\_\_\_\_

Others living in your household:

First name \_\_\_\_\_ Relationship to you \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who would you consider your emotional support network? \_\_\_\_\_

Relationship Status and History: (Circle ALL that apply that are important to your history).

Single      Married      Separated      Divorced (Single)      Divorced (Remarried)      Widowed  
Committed Relationship      Other \_\_\_\_\_

Have you had previous mental health treatment?  Yes       No  
Provider name(s) \_\_\_\_\_ Dates \_\_\_\_\_  
\_\_\_\_\_



Please check any of the following symptoms you have experienced recently. Also, indicate anything in which you have a long-standing history:

<u>Recent</u>	<u>History</u>	<u>Symptom</u>	<u>Recent</u>	<u>History</u>	<u>Symptom</u>
		Depressed or sad mood			Changes in sleep
		Crying spells			Sleeping over 10 hrs a night
		Exhaustion / tiredness			Difficulty falling asleep
		Feeling guilty, worthless, helpless, or hopeless			Frequent or early morning awakening
		Changes in appetite / eating			Sleeping only a few hours a night for several days at a time
		Not wanting to do things you once enjoyed			Decreased need for sleep
		Suicidal thoughts or bxs; thoughts of death			Frequent mood swings
		Poor body image			Feeling "too good" or "high on life"
		Low self-esteem			Increased confidence
		Sexual problems			Increased energy
		Frequent headaches			Racing thoughts
		Worry, tension, anxiety			Reckless or risk-taking bxs
		Need for control			Poor judgment
		Excessive fears			Restlessness / irritability
		Nightmares			Increased creativity / productivity
		Constant awareness of what is around you			Hearing or seeing things or ppl that others tell you are not there
		Avoiding ppl, places, things			Suspicious of others
		Urges to do things perfectly			Not desiring to be social
		Recurrent thoughts or behaviors			Fear of being outside or around others
		Angry outbursts or arguments with others			Feeling like you are not in your own body
		Aggressive behaviors			Panic attacks

CLIENT PLEASE FILL OUT TO THIS DOTTED LINE  
OFFICE USE ONLY BELOW THIS LINE



Please provide me with some information on the reasons you are seeking therapy at this time. What are you hoping to gain from therapy? \_\_\_\_\_

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Please briefly indicate anything about your current or past relationship history that would be relevant to your treatment. \_\_\_\_\_

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Please briefly describe your family of origin (parents/guardians, siblings, grandparents, etc.) How would you describe your relationships with these people during childhood? Now? \_\_\_\_\_

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Substance Use

Drug	How often	How much	Age began	Treated?	Problem bx?
Alcohol					
Marijuana					
Other – specify					

Suicide and self-harm

Current thoughts of hurting yourself? \_\_\_\_\_ Current plan/ method? \_\_\_\_\_

Previous thoughts or attempt(s)? \_\_\_\_\_

Homicide and Harm to Others

Current thoughts of hurting someone else? \_\_\_\_\_

Current plan / method? \_\_\_\_\_ History of violence? \_\_\_\_\_



Criminal Hx: Misdemeanors? Felonies? When? For what?

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Trauma hx? Physical Abuse? Sexual Abuse?

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Abuse reported? By whom? To whom? When?

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Describe education and/or work history.

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Have you ever taken any medications on a regular basis? If yes, please list medications and doses.

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Have any of your blood relatives had the following or taken medication for any of these conditions?

Depression:  Yes  No (their relation to you?) \_\_\_\_\_

Anxiety or severe nervousness:  Yes  No \_\_\_\_\_

Mental or nervous breakdown:  Yes  No \_\_\_\_\_

Alcoholism or drug addictions:  Yes  No \_\_\_\_\_

Mood swings or strange behavior:  Yes  No \_\_\_\_\_

Treatment plan / goals / additional info:

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