Clarissa J. Hill M.A., LMHC

Welcome to my practice. I look forward to working with you. This form requests information about you that will help me begin to get to know you. Please take a few moments to complete both sides of this form. These questions are designed to help me best meet your treatment needs. If you have any questions, I will be happy to answer them.

Client name ____ Birth date _______________

Address ____ Age ____________

City, State, Zip ____________________________________ Gender __________________

OK to send mail here? Y N

Your Phone Numbers (____) ____________________ (____) ____________________

Home OK to contact there? Y N — OK to leave a msg there? Y N

Mobile OK to contact there? Y N — OK to leave a msg there? Y N

(____) ____________________ Occupation ____________________________________

Work OK to contact there? Y N — OK to leave a msg there? Y N

Email Address (optional) ____

Please note that email is not a secure or confidential form of communication

Relationship Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Primary Care Physician __________________________________ (____) _______________

Name — Phone number

Emergency Contact ____________________________________ (____) _______________

Name — Relationship to client — Phone number

Please list other persons living in your household and their relationship to you:

____

____

Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision, please list the event:

____

____

What result(s) do you expect from treatment?

____

____

Have you ever received mental health treatment before? If so, please list dates, provider name, and the reason for seeking treatment:

____

____

Please list any medications you're currently taking:

____

____

CONSENT: I have read the OFFICE POLICIES AND CLIENT TREATMENT AGREEMENT and have received a copy of this information. I have clarified any questions I have and understand the information. I agree to the stated terms.

Signed: ____ Date: ________________

Patient

Signed: ____ Date: ________________

Clarissa Hill, LMHC