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. You are welcome to complete this form on your own, or to ask your parent to help you with it. 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

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

Email (optional)_____

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

Mother's name _____

Mother's phone _____

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

Father's name _____

Father's phone _____

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(s) 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