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Barrington, IL 60010
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Identifying Information

Name: ______________________________ Birthdate: ____________ Age: ________

Address: ____ ____________
(Street) (Apt/Unit#)

______________________________________ __________ ____________
(City) (State) (Zip)

Marital Status: ☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed ☐ Committed Relationship

Ethnic/Racial Identity: ______________________________

To (re)schedule appointments, where may I contact you?

☐ Cell #: ______________________________ Voicemail OK? ☐ Yes ☐ No

☐ Home #: ______________________________ Voicemail OK? ☐ Yes ☐ No

☐ Email: ____

Who may I contact in case of an emergency?

Name: ______________________________ Phone: ______________________

Relationship to you: ______________________________

Referral Source (How did you learn about my practice):

☐ Referred by ______________________________________

☐ Insurance Provider ☐ Psychology Today ☐ Network Therapy ☐ Google ☐ Other ____________

Primary Care Provider

Name: ______________________________ Phone: ______________

Clinical Information

Briefly describe your reasons for seeking services

____

____

Do you have specific goals for therapy?

____

____

Have you ever had previous counseling or psychotherapy? ☐ Yes ☐ No

Name: ______________________________ *Approx. Mo/Year:* ____________

Name: ______________________________ *Approx. Mo/Year:* ____________

Have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No
Have you ever made a suicide attempt/gesture? ☐ Yes ☐ No

Please list current medical conditions: ____

____

____

Please list current medications (prescribed & OTC):

Medication Name	Dose

Please indicate use of any alcohol and/or drugs

		Current Pattern of Use					
	Age of First Use	Daily	Weekly	In last 30 days	In Past Year	In Your Lifetime	Never
Alcohol							
Nicotine							
Marijuana							
Ecstasy or other Hallucinogens							
Cocaine and/or other stimulants							
Opioids (heroin, morphine)							
Sedatives, hypnotics, tranquilizers							

Family History:. Please use the suggested symbols to indicate if a relative has been diagnosed, treated or suspected of having with one of these health conditions. ***Dx*** *= Diagnosed.* ***Tx*** *= Received Treatment.* ***Sus*** *= You suspect they suffer from this condition.*

	Mother	*Father*	*Sibling*	*Children*	*Father's Parent*	*Mother's Parent*
Depression						
Anxiety						
Panic Attacks						
OCD						
Alcoholism						
Drug Addiction						
Suicide Attempt						
Bipolar Disorder						
ADHD						
Learning Problems						
Schizophrenia						
Thyroid Problems						
Sleep Disorder						
Other:						
Other:						

Thank you for completing the paperwork. Data is solely used for the purpose of understanding treatment concerns and will be held strictly confidential.