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Mandel Counseling

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**Demographics, Insurance & History Form**

**Client Demographic Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

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

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Contact Method: \_\_\_\_\_

How would you like to receive appointment reminders? \_\_\_ Text \_\_\_ Email \_\_\_ Phone

How did you hear of this practice? \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Payment/Insurance Information**

Insured/Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured Address: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insured Phone: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy: \_\_\_\_\_ Group: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy: \_\_\_\_\_ Group: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**Please provide the following information if it pertains to you:**

What brings you to counseling at this time?

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Are you experiencing any of these issues? (check all that apply)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Addiction                | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Impulsivity          | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Aggression/Anger         | <input type="checkbox"/> Elevated Mood   | <input type="checkbox"/> Indecisiveness       | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Loneliness           | <input type="checkbox"/> Suicidal Thoughts   |
| <input type="checkbox"/> Avoidance of People      | <input type="checkbox"/> Gambling        | <input type="checkbox"/> Memory Problems      | <input type="checkbox"/> Weight Gain or Loss |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Hallucinations  | <input type="checkbox"/> Mood Swings          | <input type="checkbox"/> Withdrawal          |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Panic Attacks        | <input type="checkbox"/> Worthlessness       |
| <input type="checkbox"/> Difficulty Thinking      | <input type="checkbox"/> Helplessness    | <input type="checkbox"/> Racing Thoughts      | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Distractibility          | <input type="checkbox"/> Hopelessness    | <input type="checkbox"/> Restlessness/On Edge | _____  |

Have you seen a therapist in the past?

Dates: \_\_\_\_\_ Clinician: \_\_\_\_\_ City/State: \_\_\_\_\_

Dates: \_\_\_\_\_ Clinician: \_\_\_\_\_ City/State: \_\_\_\_\_

Prior Psychiatric Hospitalizations:  Yes  No

Have you been prescribed psychiatric medication in the past?

<u>Medication</u>	<u>Dates</u>	<u>Outcome</u>
_____	_____	_____
_____	_____	_____

Do you have any history of substance abuse? \_\_\_\_\_

Do you have any history of legal problems? \_\_\_\_\_

Do any family members have a history of mental health or addiction issues?

<u>Family Member/Relationship</u>	<u>Diagnosis</u>	<u>Treatment/Outcome</u>
_____	_____	_____
_____	_____	_____

Have you had or do you currently have any physical health problems?

If yes, please list: \_\_\_\_\_

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Are you taking medication for physical health?

If yes, please list: \_\_\_\_\_

Who do you currently live with? \_\_\_\_\_

What was your childhood like? \_\_\_\_\_

Who are your emotional supports? \_\_\_\_\_

If you currently are in a relationship, how would you describe it? \_\_\_\_\_

How have past relationships been? \_\_\_\_\_

If you have children, what are their names and ages?

\_\_\_\_\_

If you are living with others, please list them:

\_\_\_\_\_

Have there been significant changes, losses, or crises in your life? \_\_Yes \_\_No

If yes, please describe: \_\_\_\_\_

If you have any type of belief system (moral, spiritual, cultural, religious) that influences your life, please describe: \_\_\_\_\_

What is the highest level of education you attained? \_\_\_\_\_

If you had problems in school, please describe: \_\_\_\_\_

If you have served in the military, what branch? \_\_\_\_\_ Dates of service: \_\_\_\_\_

High-risk or combat zone? \_\_\_\_\_ If not currently serving, why did you leave? \_\_\_\_\_

If you are employed, where do you work? \_\_\_\_\_ Position? \_\_\_\_\_

For how long? \_\_\_\_\_ If you are experiencing stress at work, please describe: \_\_\_\_\_

\_\_\_\_\_

What are some of your strengths? \_\_\_\_\_  
\_\_\_\_\_

What are some of your weaknesses? \_\_\_\_\_  
\_\_\_\_\_

	<b>Past</b>	<b>Now</b>	<b>Never</b>
Have you ever had thoughts of hurting yourself?	_____	_____	_____
Have you ever had thoughts of committing suicide?	_____	_____	_____
Have you ever had a plan to commit suicide?	_____	_____	_____
Have you made threats to kill yourself?	_____	_____	_____
Have you ever made a suicide attempt?	_____	_____	_____
Have you ever engaged in self-harm behaviors?	_____	_____	_____
Have you ever had thoughts of harming someone?	_____	_____	_____
Have you ever had plans to harm someone?	_____	_____	_____
Have you ever made threats to harm someone?	_____	_____	_____
Have you ever attempted to harm someone?	_____	_____	_____

What are your expectations from treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any family members or significant others you would like to involve in your treatment?  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like to share?  
\_\_\_\_\_  
\_\_\_\_\_