Client Information Date: ______________________

Name: ___________________________________ Date of Birth: ____________________ Age:________

Address: ___________________________________City___________________________Zip_______________

Home phone: _____________________________ Work/alternate phone: __________________________________

Email address:____ Cell phone: ______________________________

Employer/School: ___________________________ Occupation/Studying:_________________________________

Emergency Contact: ____________________phone:____________________ Relation to you: __________________

Referral Information

Who gave you my name to call? ____
May I have your permission to thank this person for the referral? □ YES □ NO

Family of Choice Information

Relationship status: □ Single □ Married □ Partnered □ Divorced □ Widowed □ Other: _________________

Partner's Name:__________________________Age:___________________Date of Birth:______________________

Children:
Name:_________________________Age:_____________________________Date of Birth:_____________________

Name:_________________________Age:_____________________________Date of Birth:_____________________

Name:_________________________Age:_____________________________Date of Birth:_____________________

Name:_________________________Age:_____________________________Date of Birth:_____________________

Insurance Information

Your relationship to insured: □ Self □ Spouse □ Child/Dependant □ Other

Insured's Name (if not Self) _____________________________________ Date of Birth ______________________

Social Security # ___________________________ Insurance ID# ____________________ Group # ____________

Employer _________________________________ Insurance Plan Name _________________________________

Family of Origin Information (if different from Family of Choice Information)

Father ________________________ Age ____________ Education___________ Occupation ___________________

Mother________________________ Age ____________ Education___________ Occupation___________________

Were your parents □ Divorced □ Never Married □ Still Married □ Widowed?

If divorced & remarried:
Stepparent________________________ Age ____________ Education___________ Occupation________________

Stepparent________________________ Age ____________ Education___________ Occupation________________

Brothers/Sisters?
Siblings ________________________ Age ____________ Education___________ Occupation__________________

Siblings ________________________ Age ____________ Education___________ Occupation__________________

Siblings ________________________ Age ____________ Education___________ Occupation__________________

Siblings ________________________ Age ____________ Education___________ Occupation__________________

Where are you in the birth order of siblings in your family (e.g. oldest, youngest…) ________________________

Family History of:
□ Depression □ Suicide Attempts □ Anxiety
□ Eating Disorder □ Mental Illness □ Violence
□ Sexual Abuse □ Emotional Abuse □ Alcoholism/Drug Addictions
□ Chronic Illness (please explain) ____
□ Other ____

Medical Information

Primary Physician ___________________________________ Date of Last Exam ____________________________

Do I have your permission to contact your doctor about your treatment? □ YES □ NO

If yes, phone number __________________________________

Major (or chronic) Operations/Illnesses/Injuries or any current infectious disease(s) ______________________
____
____

Current Medications Dosage(s) Frequency Effectiveness Prescribing Physician
____

____

Have you experienced any recent changes in:

□ Sleep □ Nightmares □ Amount of Exercise
□ Sexual Desire □ Eating/Appetite □ Weight
□ Suicidal Thoughts □ Concentration □ Engaging with Customary Activities/hobbies

How would you characterize your overall health?

□ Poor □ Fair □ Good □ Excellent

Do you use tobacco products? □Yes □ No If so, what? ____
Did you use tobacco in the past? □ Yes □ No
Packs per day ___________________ Beginning at what age? _____________________ When did you quit? ______

Do you consume any alcohol? □ Yes □ No

□ Less than 1x/mo □ 1-3x/mo □ 1x/week
□ Several x/week □ Every day □ Several x/day

What types?
□ Beer □ Wine □ Hard Liquor *(check all that apply)*

Do you use any street drugs or misuse prescription drugs? □ Yes □ No
Name of Drug (s) ____

Frequency of Use ____

Do you gamble or shop impulsively? □ Yes □ No If yes, how often and are you in debt because of your gambling/shopping? ____

Are you concerned about how much/how often you eat? □ Yes □ No

If yes, what, specifically, are your concerns? ____
____

Do you have any other concerns about your diet? ____

Presenting Concerns

Please describe the main concern(s) that have prompted you to see me now ______________________________________
____
____

How long have your concerns been an issue for you? ____

Worsened? Improved? Stayed about the same? ____

Please indicate your major life stressors over the past 12 months:

□ Serious illness/injury □ Death of a close friend or family member

□ Major illness in the family
□ Gain of a new family member
□ Divorce/Separation
□ Job change
□ Other ____

Please describe what you would like to be different in your life when you're done with therapy ____________

____

____

Have you ever received psychological or psychiatric counseling before? □ Yes □ No

When? From Whom? Purpose? Results?

____

____

Have you ever been prescribed medication for a psychiatric or emotional problem? □ Yes □ No

When? Prescribing Clinician? Medication? For What? Results?

____

____

____

Have you ever been hospitalized for a psychiatric or emotional health reason? □ Yes □ No

When? Where? For What Reason? Outcome?

____

____

Have you ever been in a drug or alcohol treatment program? □ Yes □ No

□ Inpatient □ Outpatient

Where? How Long? Outcome?

____

____

Social/Relationship Information

Please indicate any of the following that you have experienced:

□ Death of Mother | Your age at occurrence _____
□ Death of Father | Your age at occurrence _____
□ Death of a Child | Your age at occurrence _____
□ Death of Sibling | Your age at occurrence _____
□ Desertion by mother as a child | Your age at occurrence _____
□ Desertion by father as a child | Your age at occurrence _____
□ Divorce of parents | Your age at occurrence _____
□ Sexual Abuse | □ Emotional Abuse | □ Physical Abuse
□ Violence in the family | □ Mental illness of a family member
□ Other ____

How do you get along with your present spouse or partner? ______________________________
____

How do you get along with your children? ______________________________
____

How do you get along with your family of origin members? ______________________________
____
____

Employment Information

What do you do for employment? ______________________________

How long have you been employed at your current job? ______________________________

How satisfied are you in this job? ______________________________

Do you have other sources of income? □ Yes □ No

Please describe ______________________________

Spiritual Resources

How significant a role does spirituality play in your life?
□ None □ Somewhat important □ Significant □ Very Significant

What is your religion, if affiliated? ______________________________

Other
Is there anything else you think I should know about prior to our beginning our work together? ____________
____

Consent for Services

I have read the Disclosure Statement and have received a copy of the brochure from the Department of Health entitled, *Counseling or Hypnotherapy Clients.* I have read the DISCLOSURE STATEMENT and I have had an opportunity to ask questions about the course of treatment and do hereby consent to accept treatment from ____________________________. ______ **(initial).**

I have been given a copy of OptimalLife Wellness Center's HIPAA Notice of Privacy Practices.
_____ **(initial).**

Reimbursement

I am responsible for paying for any services not reimbursed by my insurance company within 90 days of the date of service. I am also responsible for and agree to pay all co-pays owed, at the time of service. I assign directly to OptimalLife Wellness Center all insurance benefits otherwise payable to me for services rendered. I further authorize OptimalLife Wellness Center to release all information necessary to secure payment of benefits _____ **(initial).**

Cancellations

Since the scheduling of an appointment involves the reservation of time specifically for me, I understand that a minimum of 24 hours' notice is required for re-scheduling or canceling an appointment. . I also understand that I may be charged a late cancellation or "no-show" fee equal to the cost of the session missed for appointments not canceled with at least 24 hours' notice and that this fee is not billable to insurance. OptimalLife Wellness Center does understand that occasionally unforeseen circumstances may lead to a late cancellation or even a no-show. In the event of extreme weather conditions, I understand that OptimalLife Wellness Center adheres to the Bellevue School District's decision on school closures and will contact me via phone or email to inform me of office closure. I will not be liable for missed sessions due to extreme weather conditions. ______ **(initial)**

Consent for Release to Communicate with PCP and staff at OptimalLife Wellness Center

I hereby consent for my therapist at OptimalLife Wellness Center to communicate with my Primary Care Physician as it pertains to and is beneficial to my treatment in counseling □ YES □ NO ____ **(initial).** I hereby consent for my therapist at OptimalLife Wellness Center to communicate with other clinicians on staff who are also involved in my treatment as it pertains to and is beneficial to my treatment in counseling □ YES □ NO ____ (initial).

Client's Signature	Date
Client's Signature	Date

I have truthfully represented myself in this document and agree to uphold its conditions.

Therapist	Date