Adrienne Cress, LCMHC, REAT

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Demographic Information

First Name: ______________________ Middle Initial: _____ Last Name: _______________________

Date Of Birth: _____________________ Gender: ___________

Mailing Address: ____

City: _________________________________ State: ______ Zip Code: ________________

Primary Phone : ( ) ___________________ ok to leave a message? **Y N**

Alternative Phone: ( )____________________ ok to leave a message? **Y N**

May I email you? **Yes** **No** Email address: ____

In case of an emergency, you have my permission to contact:

Name:____________________________________ Relationship: _____________________________

Phone number (s) ____

Address: ____

Presenting Concerns

Please provide a brief description of why you are seeking therapy at this time and what goals you hope to achieve by coming here:

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Describe your strengths and resources that will be helpful to you in achieving your goals in therapy:

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Are you currently or in the last 30 days have you experienced any of the following:

□ sadness	□ helpless/hopeless	□ thoughts of dying	□ no motivation
□ feeling worthless	□ can't sleep	□ sleep too much	□ fatigue/low energy
□ can't concentrate	□ easily startles	□ fearful	□ nervous
□ nervousness	□ panic attacks	□ recurring nightmares	□ restlessness
□ feeling "on edge"	□ stressed	□ irritable/angry	□ "spacing out"

□ physical symptoms (headache, stomachache, etc): ______________________________

Mental and Physical Health

Please list any previous therapy/psychiatric treatment: □ no previous treatment

Provider name: ______________________________ Dates of treatment: ________________

Provider name: ______________________________ Dates of treatment: ________________

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Hospitalizations for mental illness: ______________________________

Describe family history of mental illness: ______________________________

Primary Care Physician: ______________________________Date of last visit:______________

Other current providers of care: ______________________________

Current Medical Concerns/Conditions: ______________________________

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Current Medication Listing (use back of page if necessary):

Name of Medication (prescribed, herbal or over the counter	Dose (how much & how often	Why was it prescribed?	Current or past medication?	Length of time on medication	Side effects experienced (if any)	List any benefits of the medication	Name of Prescriber

Personal and Social Information

Marital status: ________________________ Sexual Orientation: ____________________________

Employment status: ____________________ Employer/School: _____________________________

Spiritual Orientation: ____

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Please list all members of your household/family:

NAME	AGE	RELATIONSHIP	OCCUPATION

Has a significant person or family member enter or leave your life in the last 90 days? □ Yes □ No

Billing Information

Party Responsible for Payment

First Name: ___________________ Middle Initial: _____ Last Name: _________________________

Street Address: ____

City: ___________________________________ State: _______ Zip Code: _____________________

Home Phone: ( ) ______________________ Work Phone: ( ) _______________________

Email Address: _____________________

I hereby authorize Adrienne Cress, LCMHC to release any billing information to "Party Responsible for Payment".

Client's Signature: ______________________________________ Date: ________________