Date:			
Name:			
Street Address:			
City:			
Cell phone:	Alternative p	hone #	
E-mail:			
			age(Check all that apply)
Phone: Text:	_ E-mail:		
Date of Birth:	A	.ge :	
Gender: Female: Male	e: Transge	ender:	
Gender Nonconforming:	Other: _		
Sexual Orientation: Straight: _	Gay: Lesb	oian: Bis	sexual: Asexual:
Queer:	_ Questioning:	_ other:	Prefer not to answer:
Relationship status:			
Single Married	Divorced In	na relationsl	nip
Emergency Contact Information	on:		
Name:		_ Relationsh	ip:
Phone number:	Email:		
Referral Information:			
Were you referred? Yes:	_ No:		
If Yes, by whom?			
What type of service(s) are you			
Individual therapy Marital			ily therapy
Child therapy Other (describ			
÷ •		_	Jiisuie
Goals of Treatment:			Olisuie

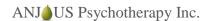
Yes: ____ No: ____

If yes, you may be required to supply supporting documentation such as a copy of court order.

Information about your hospital stay Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist). Type of Provider (Psychiatrist, Psychologist, Therapist, or Other): Phone Number: _____ Email: _____ Street Address: City: _____State: ____ Dates of treatment **Current Mental Health Treatment:** Are you currently under the **care of a psychiatrist**? Yes: _____ No: _____ If YES, please complete the following information: Name of Current Provider: Phone Number: _____ Email: ____ Street Address: City: ______ State: _____ Dates of Treatment: Focus of Treatment: If you are currently under the **care of a psychiatrist**, are you taking any prescribed psychiatric medication(s)? Yes _____ No____ If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects. For example: "Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)." Please continue on additional sheet if needed Have you participated in any psychological assessments or tests? Yes _____ No ____ *California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental

health care and/or medical providers only to discuss issues relevant to your diagnosis and

treatment without your consent. Initial: _____



Medical Treatment Information:

Client Signature Date Client Name: (Please Print)	
If you checked "Yes," you may use the space below to describe the underlying circumstance	es:
Have you been, or are you currently being, emotionally, physically, or sexually abused? Yes No Prefer not to answer	
Trauma History (Optional):	
Current or past Drug/Alcohol/Eating disorders? Yes No If yes please provide more details:	
Are you experiencing any suicidal/ homicidal ideation or attempts? Yes No If yes please provide more details:	
Dates of Treatment:	
City: State:	
Street Address:	
Phone Number: Email:	
Primary Care Physician: Name:	
If you are currently taking prescribed medications, please describe the type of medication, indicate how long you have been taking the medication, and any side effects. For example: "High blood pressure medication (type of medication); 2 years (length of time on medication Drowsiness (example of a side effect). Please continue on additional sheet if needed.	on);
Is it a medically treatable condition? Yes: No: If, it is not a medically treatable condition (i.e., palliative care), please describe:	
How long have you had the condition?	
If you currently have a medical condition, please provide the following information: Current medical condition:	
Are you currently seeking treatment for a serious or chronic non-psychiatric medical conditives: No:	ion?