Jennifer Worcester, MA, LPC
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Client Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____Can I contact you at this email address? Yes No

Home Phone: _____ Can messages be left at this number? Yes No

Cell Phone: _____ Can messages be left at this number? Yes No

Date of Birth: _____ Last 4 digits of your social security number: _____

Children's Names M/F Age Mother/Father's Name Do they live with you?

_____

_____

_____

Relationship Status (Single, Married, Life Partner, Dating, or Other) : _____

Emergency Contact Person: _____ Phone: _____

Relationship of Emergency Contact: _____

Do you currently have any ongoing court cases? If yes, please describe:_____

_____

Financial Responsibility:

Who is financially responsible for services? _____

Insurance Company: _____

Insurance Company Address: _____

Policy Holder's Name: _____

Policy Holder's Social Security # : _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____

Policy Holder's Employer: _____ Work Phone Number: _____

Family History:

	Living?	Age or Age at Death	Present Health/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you have any family history of mental illness? (Bipolar, Schizophrenia, Depression, etc.) Yes No

Do you have any family history of learning difficulties or behavior problems? Yes No

If you answered yes to the above questions, please provide additional information below:

_____

_____

Medical /Mental Health History:

Family Physician: _____ Phone Number: _____

Date of last physical: _____ Date of last hospitalization: _____

Please list any previous counseling or other relevant treatment (counseling, hospitalization, etc.):

Provider's Name:	Date Began:	Date Ended:

Please list current and previous medications:

Medication:	Dosage:	Date Began:	Date Ended:	Prescribing Physician:

Have you ever been given a mental health diagnosis?	Yes	No
Have you ever been hospitalized for mental health reasons?	Yes	No
Have you attempted suicide in the past?	Yes	No
Do you have thoughts of harming yourself or someone else at this time?	Yes	No
Have you been diagnosed with any mental Illness?	Yes	No
Have you ever received treatment for substance abuse?	Yes	No
Do you use tobacco?	Yes	No
Do you use alcohol?	Yes	No
Do you use any other substances such as marijuana, cocaine, amphetamines, etc.?	Yes	No

Please circle any of the following symptoms/conditions that are present now or in the past:

Headaches	Irritability	Diabetes	Stress
Dizziness	See or Hear Things that are not There	Abuse	Anxiety
Head Injury	Weight Gain or Loss	Fertility	Marital
Thyroid Problems	Thoughts of Self Harm	Sexual Problems	Feeling Out of Control
Fatigue	Depression	Anemia	Difficulty Sleeping
Heart Trouble		Allergies	
		Legal Problems	

Please list/describe any other medical disease/condition that you may have or experienced that is not mentioned above:

_____

_____

Do you have any history of emotional, physical, or sexual abuse? If so, please describe below:

_____

_____

Other:

What are your reasons for seeking counseling/parenting services at this time?

_____

_____

Is there anything else you would like to share that was not asked above?

_____

_____

How were you referred to Capitol Peak Counseling or Jennifer Worcester?

_____