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?

____

____

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

___Addiction	___Eating Problems	___Impulsivity	___Sexual Difficulties
___Aggression/Anger	___Elevated Mood	___Indecisiveness	___Sleeping Problems
___Anxiety	___Fatigue	___Loneliness	___Suicidal Thoughts
___Avoidance of People	___Gambling	___Memory Problems	___Weight Gain or Loss
___Depression	___Hallucinations	___Mood Swings	___Withdrawal
___Difficulty Concentrating	___Headaches	___Panic Attacks	___Worthlessness
___Difficulty Thinking	___Helplessness	___Racing Thoughts	___Other:________________
___Distractibility	___Hopelessness	___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?

Medication	Dates	Outcome
______________________________________	_______________	______________________________________
______________________________________	_______________	______________________________________
______________________________________	_______________	______________________________________

Do you have any history of substance abuse? ____

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

Family Member/Relationship	Diagnosis	Treatment/Outcome
______________________________________	_______________	______________________________________
______________________________________	_______________	______________________________________

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

If yes, please list: ____

____

____

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? ____
____

	Past	Now	Never
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?
____
____