MARYANN H. COX, LCSW

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Please provide the following information and answer the questions below. Please note that information provided here is protected as confidential information.

Name: ____

Address: ____

____

Phone- home: __________________ May I leave a message? __Y __N

Phone- mobile: __________________ May I leave a message? __Y __N Text you? __Y __N

Phone- work: __________________ May I leave a message? __Y __N

E-mail: ____ May I email you? __Y __N
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Birth Date: ______ /______ /______ ◻ Male ◻ Female

Marital Status: ◻ Never Married ◻ Domestic Partnership ◻ Married ◻ Separated

◻ Divorced ◻ Widowed

Emergency contact: _______________________________ Phone: _________________

Relationship: __________________________

INSURANCE INFORMATION

Name of Subscriber: ____

Insurance Company: ____

Policy ID Number: ____

Group Number: ____

Birthdate of Subscriber: ______ / _______/ ________

Relationship to subscriber: Self Spouse Child

Name: ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, If yes, previous therapist/practitioner:

____

Are you currently taking any prescription medication?
□ No □ Yes

Please list:
____

____

Have you ever been prescribed psychiatric medication?
□ No □ Yes

If yes, please list & provide year
____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

(Please continue to other side)

3. How many times per week do you generally exercise? __________

What types of exercise do you participate in: ________________________________

4. Please list any difficulties you experience with your appetite or eating patterns:

____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes

If yes, for about how long? ________________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes

If yes, about when did you begin experiencing this? ___________________________

7. Are you currently experiencing any chronic pain?
□ No □ Yes

If yes, please describe? ___________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

If yes, how many times per week, on average? ______________

How much do you drink, on average, when you drink? _________

Have you ever worried about your drinking? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

Name: ____________________________

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no
Anxiety	yes/no
Depression	yes/no
Domestic Violence	yes/no
Eating Disorders	yes/no
Obesity	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

(Please continue to other side)

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths or assets?

____

____

4. What do you consider to be some of your liabilities?

5. What would you like to accomplish out of your time in therapy?