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Instructions: Please print this form and fill out as much information as you are able, sign, date, and bring it with you to your Initial Intake appointment. Use reverse side for additional information.

INITIAL INFORMATION FORM - PERSONAL AND CONFIDENTIAL

* A separate form is to be completed by each person attending therapy (Please print or type) - Male Female

Name: _____ Date: _____

Home Address _____ City/State/Zip _____

Mailing Address _____ City/State/Zip _____

Email Address _____

Home Phone _____ / _____ Msg ok No msg No calls

Work Phone _____ / _____ Msg ok No msg No calls

Cell/other _____ / _____ Msg ok No msg No calls

Date of Birth _____ - _____ - _____ Birthplace _____

Ethnicity (Circle): Caucasian - Hispanic - Asian/Pacific Islander - African American - Native American

Other _____

Status: Single Separated Married Divorced Widowed Partners

If married, how long? _____ if partnered, how long? _____

Have you ever been married before? Yes No (circle one) If yes, when and for how long? _____

Do you have Mental Health Insurance? Yes No (circle one) If yes, are you planning on using it? _____

Insurance / Superbill Information (if applicable)

Insurance Company:	
Policy Holder Name:	Relationship to Client:
Insurance Company Address:	Telephone:
Policy # / ID #:	Group #:

Note on Insurance: Full payment is due at the time of service. Upon request, a Superbill will be provided. A Superbill is an invoice using standardized codes for treatments received, which you can submit directly to your insurance company for reimbursements. Please call your insurance company prior to beginning therapy for verification of benefits and other details.

Occupation _____ Monthly Gross Income _____

Employer _____

Address _____

_____ Phone (optional) _____ / _____

How were you referred? (Web page, flyer, Ad, personal reference?) _____

Names & ages of persons living in your home, and your relationship to them _____

Please list names and ages of your children, if any _____

Emergency Contact _____

Phone: _____ / _____ Relationship to you _____

Days & Times you are Available for Counseling: _____

Please describe briefly, the reasons you are seeking counseling: _____

Goals for counseling: _____

Check any of the Following that apply to you:

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Inferiority Feelings	<input type="checkbox"/>	Shy With People
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Feel Tense	<input type="checkbox"/>	Can't Make Friends
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Feel Panicky	<input type="checkbox"/>	Afraid Of People
<input type="checkbox"/>	No Appetite	<input type="checkbox"/>	Fears and Phobias	<input type="checkbox"/>	Home Conditions Bad
<input type="checkbox"/>	Over-Eating	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	Unable To Have A Good Time
<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Always Worried About Something
<input type="checkbox"/>	Bowel Disturbances	<input type="checkbox"/>	Suicidal Ideas	<input type="checkbox"/>	Don't Like Weekends/Vacations
<input type="checkbox"/>	Always Tired	<input type="checkbox"/>	Take Tranquilizers	<input type="checkbox"/>	Can't Make Decisions
<input type="checkbox"/>	Always Sleepy	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Over-Ambitious
<input type="checkbox"/>	Unable To Relax	<input type="checkbox"/>	Dangerous Drugs	<input type="checkbox"/>	Financial Problems
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	Recurrent Dreams	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Job Problems
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Sexual Orientation	<input type="checkbox"/>	Can't Keep A Job
<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	Other

Have you ever been in counseling before, including individual, group, marital or family? Yes No (circle one)

If yes, give dates & type _____

Have you ever been hospitalized for psychological/emotional difficulties or/and eating disorder, surgery, childbirth?

Yes No (circle one) If yes, give dates & type of medication _____

Have you ever been hospitalized for medical reasons; i.e.: alcohol, drugs, eating disorder, and surgery?

Yes No (circle one) If yes, give dates and reasons _____

Has any physician ever prescribed medication for psychological problems/emotional difficulties or an eating disorder?

Yes No (circle one) If yes, who, dates and type of medication _____

Are you currently using any prescribed or non-prescribed medication? Yes No (circle one)

If yes, name of medication, dosage and reason prescribed (including illegal drugs & alcohol) _____

Have you ever experienced physical, sexual or emotional abuse? Yes No (circle one)

Have you ever had a physical fight with your spouse or partner (such as throwing things, shoving, or hitting?)

Yes No (circle one) If yes, please specifically explain _____

Have you ever physically harmed anyone? Yes No (circle one) If yes, please explain _____

Have you ever been arrested for a crime? Yes No (circle one)

If yes, please explain _____

Has anyone in your family (parents, siblings) had a diagnosed psychological or emotional problem?

Yes No (circle one) If yes, please specify _____

Has anyone in your family (parents, siblings) had a substance use or abuse problem? Yes No (circle one)

If yes, who, what problem and when? _____

Upon my signature below, I hereby attest that all the information furnished is true and correct.

Signature _____ Date _____

Reminder: Please print, complete and sign this form, bring it with you to your Intake Appointment. You may wish to *make copies* of this information for your own records.