

# Shannon Lee, LMFT

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Although some questions here may seem unnecessary, they will help me to better understand you and your situation. Please fill in all information as this information is required by most insurance companies.

### Personal Information

Date: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Ok to send mail: \_\_\_\_\_  
If no, please provide alternate address: \_\_\_\_\_  
Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Ok to leave a message: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Ok to leave a message: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ok to leave a message: \_\_\_\_\_  
Email account: \_\_\_\_\_  
Name of emergency contact: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_  
Referral Source (how you heard about therapy services): \_\_\_\_\_  
Will you give permission for this office to send the referral source a thank you note? Yes \_\_\_\_\_ No \_\_\_\_\_  
What kind of services are you seeking? \_\_\_\_\_ Individual counseling \_\_\_\_\_ Couples counseling \_\_\_\_\_  
Group counseling \_\_\_\_\_ Family counseling \_\_\_\_\_ Brief problem solving \_\_\_\_\_  
Required letter/documentation \_\_\_\_\_ Alcohol/Drug assessment \_\_\_\_\_

### Insurance Information

Carrier: \_\_\_\_\_ ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Provider Phone # (on the back of the card): \_\_\_\_\_  
Primary Insured's Name/SS#/Date of Birth: \_\_\_\_\_

### Health Information

Please answer the following questions using: 5 Excellent- 4 Good- 3 Average- 2 Poor- 1 Failing

How would you currently rate your physical health: \_\_\_\_\_

How would you currently rate your mental health: \_\_\_\_\_

How would you currently rate your spiritual health: \_\_\_\_\_ (if does not apply to you, please use N/A)

Please list current symptoms (reason you are here) and circle those you currently find most bothersome:

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### Medical Information

Are you currently under the care of a Doctor or other medical health professional: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Specialist Physician: \_\_\_\_\_ Physician Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

Do you now have, or have you had in the past, any of the following? Check all that apply:

Asthma			Allergies			Headaches		
Brain Injury			Epilepsy			Seizures		
Digestive Disorder			Cancer			Diabetes		
Breathing Problem			Immune System Problems			Hearing Problems		
High Blood Pressure			Vision Problems			Tuberculosis		
Arthritis			Urinary Disorders			Chronic Fatigue Syndrome		
Thyroid Disorder			Multiple Sclerosis			Miscarriage (how many)		
Fibromyalgia			Pregnancy (how many)			Sleep Disorder		
Abortion (how many)			Sexually Transmitted Disease			Other		

Asthma			Allergies			Headaches		
Serious Accident			Surgery					

Please list any prescription medications you are currently taking with dosage and milligram information:

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Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

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Do you currently exercise: \_\_\_\_\_ If yes, please indicate how many times per week: \_\_\_\_\_

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Meth-amphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

Have you ever believed your substance use was a problem for you: \_\_\_\_\_

Has anyone ever told you they believed your substance use was a problem: \_\_\_\_\_

Have you ever had withdrawal symptoms when trying to stop using any substances: \_\_\_\_\_

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: \_\_\_\_\_

Have you ever participated in drug and alcohol treatment: \_\_\_\_\_ If yes, please list type, length, dates, and age at time you received these services: \_\_\_\_\_

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous: \_\_\_\_\_ If yes, please list length of time sober and number of meetings you attend per week \_\_\_\_\_

### **Mental Health Information**

Have you ever been in counseling/therapy before: \_\_\_\_\_ If yes did you find it helpful or effective: \_\_\_\_\_

Are you currently receiving mental health services: \_\_\_\_\_ If yes, please list name of practitioner and type of services you are receiving: \_\_\_\_\_

Have you ever been hospitalized for mental health concerns: \_\_\_\_\_ If yes, list date(s) and length of stay: \_\_\_\_\_

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date (s) first diagnosed: \_\_\_\_\_

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) and illness(es): \_\_\_\_\_

Have you ever or are you currently engaging in self harm? Currently: \_\_\_\_\_ Past: \_\_\_\_\_

Have you ever or are you currently contemplating suicide? Currently: \_\_\_\_\_ Past: \_\_\_\_\_

Have you ever or are you currently contemplating harming another person? Currently: \_\_\_\_\_ Past: \_\_\_\_\_

Have you ever or are you currently engaging in violent acts/behavior? Currently: \_\_\_\_\_ Past: \_\_\_\_\_

If yes (violent acts/behavior) please describe: \_\_\_\_\_

Have you ever attempted suicide: \_\_\_\_\_ If yes please list date(s), method(s), and your age at time of attempt: \_\_\_\_\_

Has any one in your family ever attempted suicide: \_\_\_\_\_ If yes please list relationship: \_\_\_\_\_

Has any one in your family ever completed suicide: \_\_\_\_\_ If yes please list relationship: \_\_\_\_\_

Has any one else in your life ever attempted \_\_\_\_\_ or completed suicide: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you currently or have you ever had trouble sleeping: \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Do you currently or have you ever had problems with eating or with food: \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Briefly describe why you are coming in for therapy and the goals you hope to achieve in therapy:

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Family History of Alcoholism and/or Violence:

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**Spiritual Information**

Have you ever or do you currently engage in a personal faith practice: \_\_\_\_\_ If yes please describe: \_\_\_\_\_

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Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc.): \_\_\_\_\_ If yes, please describe your current level of connection and involvement: \_\_\_\_\_

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**Relationship Information**

Are you currently in a relationship: \_\_\_\_\_ If yes, please list status: \_\_\_\_\_

Name of Person: \_\_\_\_\_ Length of time you have known each other: \_\_\_\_\_

Length of time you have been together: \_\_\_\_\_ Do you currently live together: \_\_\_\_\_

Number of marriages: \_\_\_\_\_ Number of divorces: \_\_\_\_\_ If widowed, your age at death of spouse: \_\_\_\_\_

Do you have children: \_\_\_\_\_ If yes, please list below:

Name	Age	Resides with you or elsewhere

If you are coming in for Couples or Family counseling, or are currently experiencing relationship difficulties you would like to address in individual counseling, please briefly describe: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Other persons living in your household and your relationship to them: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Information**

Were you adopted: \_\_\_\_\_ If yes, your age at time of adoption: \_\_\_\_\_

With whom did you live until the age of 18: \_\_\_\_\_

Did your parents ever divorce: \_\_\_\_\_ If yes, your age at time of divorce: \_\_\_\_\_

If divorced, did your parents ever re-marry: \_\_\_\_\_ If yes, list parent(s) and your age(s) at time of remarriage: \_\_\_\_\_

Were you ever in foster care or residential care: \_\_\_\_\_ If yes, please list age and living situation: \_\_\_\_\_

Mothers current age: \_\_\_\_\_ If deceased, her age at death: \_\_\_\_\_ Your age at time of her death: \_\_\_\_\_

Fathers current age: \_\_\_\_\_ If deceased, his age at death: \_\_\_\_\_ Your age at time of his death: \_\_\_\_\_

Do you have siblings: \_\_\_\_\_ If yes, please list names, ages, and relationship: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever experienced the death of a family member or a close friend: \_\_\_\_\_ If yes please list relationship and your age at time of their death: \_\_\_\_\_

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				Frequent/Multiple Moves			
Sexual Abuse				Homelessness			
Domestic Violence				Lived over-seas			

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Neglect				Financial Problems			
Substance Abuse				Military Member			
Serious Illness				Discrimination			
Accident or Injury				Other			

**Educational Information**

Number of years of education completed: \_\_\_\_\_ Degree(s) achieved (please mark all that apply):

High School Diploma		G.E.D.		Vocational/Trade School Certificate		Associates Degree	
Bachelors Degree		Masters Degree		Doctorate Degree		Other	

**Vocational Information**

Are you currently employed: \_\_\_\_\_ If yes, please list position title, name of employer, type of work, and length of time at employment: \_\_\_\_\_

If you are not currently working, how long have you been un-employed: \_\_\_\_\_

What types of jobs have you typically held: \_\_\_\_\_

What is the longest period of time you have ever worked at one job: \_\_\_\_\_

Are you currently considering a change in job or career: \_\_\_\_\_ If yes, what type of work are you interested in doing: \_\_\_\_\_

Have you ever served in the military: \_\_\_\_\_ If yes, please list branch, rank, and current status (active/discharged): \_\_\_\_\_

If deployed please list dates and family/relationship status pre and post deployment: \_\_\_\_\_

Please list your personal hobbies and interests: \_\_\_\_\_

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**Legal Information**

Have you ever been the victim of a crime: \_\_\_\_\_ If yes, please list date and briefly describe: \_\_\_\_\_

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Are you currently involved in divorce or child custody proceedings: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

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Have you ever been convicted of a misdemeanor or felony: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

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