Debra R Hargett, LCSW L8120

210 E. 6th Ave., Junction City, OR 97448

phone: 541-556-3850 secure email:

debrarachelle@therapytoshine.com

Client Registration Date: _____

Client Information

Name: _____Date of birth: _____ Age:____

Address:_____City:_____

State:_____ DL# _____

Gender as Specified on Insurance: Male ___Female __

Gender Self-Identification, if different. Male __ Female __ Other__

Preferred pronouns: She/her/hers__ He/h1m/h1s __They/them/theirs__ Ze/hir Other: ____

Relationship Status:_____

Home/cell phone:_____Message OK? ❑ Yes ❑ No

Work phone:_____Message OK? ❑ Yes ❑ No

Email: _____Message OK? ❑ Yes ❑ No

Occupation: _____

Employer:_____

Emergency Contact:_____

Relationship to Patient:_____ Emergency Contact home/cell phone:_____ Emergency Contact work phone:_____

Billing information (if different from above or client is a minor)

Name: _____Date of birth: _____ Age:____ Address:_____City/State/ Zip_____

Sex: M F Relationship to Client (if client is minor)_____

Home/cell phone:{ } ____-____Work phone: ___- ____-____ Other phone: ___-___-__

Email:_____

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Confidential History Date: _____

Name_____

Education level _____ Current Occupation _____
Satisfied with your occupation? ❑ Yes ❑ No comment: _____
Ethnicity _____ Religion/Spiritual_____
Relationship Status (Check all that apply):

❑ married ❑ living together
❑ custodial parent remarried

Years Married or Committed Relationship _____

Are there current relationship problems?_____
_____
_____

Spouse/Partner's Name_____
Highest level of education _____
Occupation_____ Satisfied with job? ❑ Yes ❑ No

❑ never married ❑ divorced ❑ separated ❑ non-custodial parent remarried
❑ Yes ❑ No comments:_____

Children ❑ Yes ❑ No

Name _____Age_____

Name _____ Age_____

Name _____ Age_____

Mother's Name _____Stepmother? ❑ Yes ❑ No

Highest level of education _____Occupation _____

Father's Name_____ Stepfather? ❑ Yes ❑ No

Highest level of education _____Occupation _____

Siblings

Name _____
Name _____
Name _____
Please list any major medical conditions in your
family:_____
_____
_____
_____

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Your medical conditions or health issues:

_____
_____
_____

Current Physician: Dr. _____

Phone # {____}____-_____

Date of most recent visit _____
Reason_____

Medications you take
Medication: _____

For what condition:_____
Medication: _____
For what condition:_____

Medication: _____
For what condition:_____

Medication: _____

For what condition:_____
Please describe other serious illnesses or injuries

_____

❑ I do not take prescription medication at this time

Is there any family history of treatment for psychological/psychiatric conditions?

❑ Yes ❑ No

Describe:

_____
_____
_____
_____

Have you had previous counseling or psychotherapy? ❑ Yes ❑ No
With whom and when:

_____

_____

Have you ever felt suicidal? ❑ Yes ❑ No Do you feel that way now? ❑ Yes ❑ No
comment:_____

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Are involved in any legal proceedings? ❑ Yes ❑ No comment:

_____

_____

Have you ever been arrested? ❑ Yes ❑ No

Have you been convicted of a crime? ❑ Yes ❑ No
comment:_____

Do you drink alcohol?

❑ Yes ❑No What type:_____Frequency:_____

Do you use tobacco? ❑ Yes ❑No What type:_____Frequency:_____

Do you use other drugs? ❑ Yes ❑No

What type:_____Frequency:_____ Comments:

_____

What are your main concerns/reasons for seeking treatment?

_____

_____

_____

_____

Did a specific event lead to this session? ❑ Yes ❑ No comment:

_____

_____

Have you been a victim of physical or sexual abuse/assault? ❑ Yes ❑ No
comment:_____

_____

Is there anything significant the form did not ask that you would like to add?

_____

_____

_____

_____

Client Referred by:_____

The *Informed Consent for Psychotherapy and Office Policies* and *Notice of Privacy Policies* must be read, understood, and signed by the end of the first session. Please feel free to ask your therapist any questions you might have regarding these documents.

For office use:
Privacy Policy returned, date: _____ Informed Consent returned, date: _____