

DEBORAH J. MORAN, M.S., PLLC

DATE: _____

CLIENT INFORMATION

NAME: _____

PHONE: (W) _____ (H) _____ (CELL) _____

ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE _____ FEMALE _____ DATE OF BIRTH: _____

MARRIED OR PARTNERED: ___ SINGLE: ___ SEPARATED: ___ DIVORCED: ___ OTHER: _____

OTHERS LIVING IN HOME (NAMES, AGES, RELATIONSHIP): _____

EMPLOYER: _____ POSITION: _____

LENGTH OF EMPLOYMENT: _____ EDUCATION: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

LIST ANY SIGNIFICANT HEALTH PROBLEMS: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DOSAGE: _____

HAVE YOU OR DO YOU USE: ALCOHOL? ___ OTHER RECREATIONAL DRUGS? ___ IF YES PLEASE LIST
NAME OF DRUG, QUANTITY USED AND HOW OFTEN? _____

HAVE YOU BEEN IN THERAPY BEFORE: YES ___ NO ___ IF YES, WHEN: _____

NAME AND LOCATION OF THERAPIST: _____

GIVE A BRIEF DESCRIPTION OF ISSUES WORKED ON: _____

HAVE YOU HAD: THOUGHTS ABOUT SUICIDE (PAST OR PRESENT)? _____ NUMBER OF ATTEMPTS _____

CURRENT ISSUES YOU WOULD LIKE TO WORK ON: _____

REFERRED BY (THERAPIST, PHYSICIAN, FRIEND, ETC.): _____

MAY I CONTACT HIM/HER TO ACKNOWLEDGE THE REFERRAL? YES / NO

NEAREST RELATIVE, OTHER THAN SPOUSE/PARTNER: _____

PHONE: _____ RELATIONSHIP TO YOU: _____

CONFIDENTIALITY STATEMENT: ALL INFORMATION SHARED IN SESSION IS CONFIDENTIAL EXCEPT IN CIRCUMSTANCES GOVERNED BY THE LAWS INCLUDING THE MANDATORY REPORTING OF ALLEGED HARM TO SELF OR HARM TO OTHERS, PARTICULARLY IN THE CASE OF CHILD, HANDICAPPED PERSON, OR ELDER ABUSE.

CLIENT INFORMATION (CONT.)

Problems

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Depressed Mood or Sadness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Spousal Abuse | <input type="checkbox"/> Self-Mutilation |
| <input type="checkbox"/> Loss of Pleasure | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> High Risk Behavior | <input type="checkbox"/> Death of a loved one |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Loneliness/Emptiness | <input type="checkbox"/> Risk to Others | <input type="checkbox"/> Other Losses |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Recent Move |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Detachment | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Isolation | <input type="checkbox"/> Feeling on Edge | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Worry | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Elder Care |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Physical Pain | <input type="checkbox"/> Legal Difficulties | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Frequent Crying | <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Work Difficulties | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Insomnia (Too little sleep) | <input type="checkbox"/> Intrusive Thoughts | <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hypersomnia (Too much sleep) | <input type="checkbox"/> Irrational Fears | <input type="checkbox"/> Lying | _____ |
| <input type="checkbox"/> Fatigue/Low Energy | <input type="checkbox"/> Confusion | <input type="checkbox"/> Too much energy | _____ |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Repetitive Thoughts | <input type="checkbox"/> Impulsiveness | _____ |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> School Difficulties | <input type="checkbox"/> Suicidal Thoughts | |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Sexual Concerns | <input type="checkbox"/> Suicidal Attempts | |
| | <input type="checkbox"/> Relationship Difficulties | <input type="checkbox"/> Homicidal Thoughts | |
| | <input type="checkbox"/> Stress | <input type="checkbox"/> Homicidal Attempts | |

How long have you had these problems: _____ week(s) _____ month(s) _____ year(s)

Have you had prior counseling? (include hospitalizations): Y / N

Name of therapist/counselor: _____ Location: _____
For Help With: _____ When/How Long: _____
Name of therapist/counselor: _____ Location: _____
For Help With: _____ When/How Long: _____
Name of therapist/counselor: _____ Location: _____
For Help With: _____ When/How Long: _____

Medications: change/new no change no medications

Medication: _____ Dosage: _____ For: _____
Medication: _____ Dosage: _____ For: _____
Medication: _____ Dosage: _____ For: _____
Medication: _____ Dosage: _____ For: _____

Family: A brief description of any issues in your family growing up (Please include Health, Mental Health, Alcohol/Drug use): _____

Past Experiences

Physical Abuse: At what age(s)? _____ By Whom: _____
 Verbal Abuse: At what age(s)? _____ By Whom: _____
 Emotional Abuse: At what age(s)? _____ By Whom: _____
 Sexual Abuse: At what age(s)? _____ By Whom: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I _____, acknowledge that I have received a copy of the Notice of Privacy Practices for Deborah J. Moran.

Client/Parent/Guardian

Date

Client/Parent/Guardian

Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal representative's Name

Relationship to Client

For Office Use Only

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented me from obtaining acknowledgement

Other: Please specify

This form will be retained in your medical record. This form is educational only, does not constitute legal advice, and covers only federal, not state law.