

**Sandra Mathews, MSW**

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Applicant name		Email	
Address		City	State
		Zip code	
Home telephone ( ) OK to call? <input type="radio"/> Y <input type="radio"/> N OK to leave message? <input type="radio"/> Y <input type="radio"/> N		Work telephone ( ) OK to call? <input type="radio"/> Y <input type="radio"/> N OK to leave message? <input type="radio"/> Y <input type="radio"/> N	
Gender <input type="radio"/> M <input type="radio"/> F	Birthdate ____/____/19____	Relationship status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Partnered <input type="radio"/> Living Together	
Education <input type="radio"/> Less than HS <input type="radio"/> HS grad/equiv <input type="radio"/> College <input type="radio"/> Graduate degree		Ethnicity <input type="radio"/> Black/African American <input type="radio"/> White <input type="radio"/> Asian/Pacific Islander <input type="radio"/> Native American <input type="radio"/> Latino/a <input type="radio"/> Mixed Race <input type="radio"/> Other (Specify):_____	
Spouse/partner's name		Birthdate	Telephone ( )
Emergency contact name		Relationship	
Telephone number ( )		Address	

Name of child	DOB	Lives with you?

<p><b>Insurance information</b> <i>(Please complete)</i></p> <p>Applicant's name: Employer: Insurance co.: Ins. ID # or SSN: Group #:</p>	<p><b>Secondary insurance holder's insurance information</b> <i>(Please complete)</i></p> <p>Partner's name: Employer: Insurance co.: Ins. ID # or SSN: Group #:</p>
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Describe any medical problems and/or allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all prescribed and unprescribed medications and dosages (current, past 6 months). Include any adverse medical reactions:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When was your last physical? _____	Name of provider:
Have you had outpatient counseling before? <input type="radio"/> Y <input type="radio"/> N	Inpatient/substance abuse treatment? <input type="radio"/> Y <input type="radio"/> N
Duration of treatment/s:	Was treatment/counseling helpful?

What are the chief concerns bringing you to therapy?

How have these problems affected your:													
	N/A	Not At All			Very Much		N/A	Not At All			Very Much		
Marriage/partner?	<input type="radio"/>	1	2	3	4	5	Mood?	<input type="radio"/>	1	2	3	4	5
Family?	<input type="radio"/>	1	2	3	4	5	Eating habits?	<input type="radio"/>	1	2	3	4	5
Job/school performance?	<input type="radio"/>	1	2	3	4	5	Sleeping habits?	<input type="radio"/>	1	2	3	4	5
Friendships?	<input type="radio"/>	1	2	3	4	5	Ability to concentrate?	<input type="radio"/>	1	2	3	4	5
Financial situation?	<input type="radio"/>	1	2	3	4	5	Child rearing?	<input type="radio"/>	1	2	3	4	5
Legal situation?	<input type="radio"/>	1	2	3	4	5	Ability to control your temper?	<input type="radio"/>	1	2	3	4	5
Health?	<input type="radio"/>	1	2	3	4	5	Spirituality?	<input type="radio"/>	1	2	3	4	5
Anxiety level/nerves?	<input type="radio"/>	1	2	3	4	5							

How do you think your behavior would be viewed by those who know you best, who are most affected by you? What would they comment?

What do you hope to learn from therapy?

**Substance Use**

Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)?  Y  N

Has a friend or relative discussed concerns about your use?  Y  N

Have you ever felt guilty about your drinking or drug use?  Y  N

Have you ever had to take a drink or use a drug the next day to steady your nerves?  Y  N

Are you a recovering alcoholic or recovering drug addict?  Y  N

Is there a history of problems with alcohol or drug use in your family?  Y  N

Anything else you'd like to add: