**PERSONAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name: | Middle Initial: |
| Date of Birth: | Gender: | Age: |
| Preferred Phone: | Can I leave a message? (Y/N) |  |
| Secondary Phone: | Can I leave a message? (Y/N) |  |
| Address: |  |  |
| Email Address: | Can I send you emails about appointments? (Y/N) |  |
| Emergency Contact\* Name (& Relationship): | Phone Number: |  |

\*I will only contact this person in the case of a life-threatening emergency.

**BILLING INFORMATION**

|  |  |  |
| --- | --- | --- |
| Occupation: | Employer: | Income (Monthly / Annual): |
| Relationship Status: | Number of Dependents: |  |
| Please note any concerns related to payment or billing: |  |  |

**MEDICAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Primary Care or Prescribing Physician: | Physician Phone: | Physician Office Location: |
| Current medical issues or diagnoses: |  |  |
| Current medication and dosage: |  |  |
| Is your current medication helpful? (Please explain): |  |  |
| Please describe other important medical information: |  |  |

**MENTAL HEALTH INFORMATION**

|  |
| --- |
| Have you previously received any kind of mental health services? If yes, when and where?: |
| Is/was it helpful?: |

**SOCIAL INFORMATION**

Household members:

|  |  |  |  |
| --- | --- | --- | --- |
| First Name | Age | Relationship | What is your relationship like? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you or your family members ever suffered from the following?:

|  |  |  |
| --- | --- | --- |
|  | Self | Family Member (specify who) |
| Anxiety |  |  |
| Depression |  |  |
| Trauma |  |  |
| Substance Issues |  |  |
| Other: |  |  |

**ADDITIONAL INFORMATION**

|  |
| --- |
| What is your primary reason for seeking services?: |
| What goal(s) do you have for treatment?: |

How did you hear about Jessica Tupa, LPCC?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_