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Psychotherapy & Wellness Counseling
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Framingham, MA 017029
(508) 626-8778

CLIENT INFORMATION

Date: _____

NAME: _____

ADDRESS: _____

Home phone: _____

Work phone: _____ Ext. _____

Cell phone: _____

Email address: _____

Please indicate which method(s) above I should use in contacting you:

DOB: _____

SSN: _____

Referred by: _____

Employer: _____

Occupation: _____

Emergency Contact: _____

Relationship: _____

Contact Telephone: _____

HEALTH INSURANCE INFORMATION:

Insurance Company: _____
Policy #: _____
Group #: _____
Phone # on card for mh/sa: _____
Who is insurance under? _____
DOB of insured: _____ SS#: _____

PRIMARY CARE PHYSICIAN INFORMATION:

Name: _____
Address/Hospital Affiliation: _____
Telephone: _____
When was your last visit? _____ Reason: _____

HEALTH INFORMATION:

Briefly describe past/current medical treatment and hospitalizations (both medical and psychiatric): _____

Please list all medications you are currently taking including dosage and duration of use:
(Use back of sheet as needed).

1. _____
2. _____
3. _____

Circle ANY of the following that are currently contributing to your seeking counseling:

- | | | |
|---------------------|-------------------|--------------------|
| Depression | Anxiety | Physical pain |
| Relationship issues | Weight loss/gain | Addictions |
| Chronic illness | Sexual concerns | Family concerns |
| Body image issues | Suicidal ideation | Self-esteem issues |
| Sleep disturbance | Phobias | Eating disorders |

Mood swings

Grief/Bereavement

Money management

Parenting issues

Pregnancy

Pregnancy loss/infertility

OTHER: _____

What is your chief concern/issue at this time?

Have you sought psychotherapeutic assistance in the past?

If yes, are you currently seeking it for the same reason(s)?

Please provide the name(s) and number(s) of prior mental health clinicians who you have seen for treatment and approximate dates of treatment:

1. _____

2. _____

3. _____

Have you even attempted suicide, had a plan to commit suicide, or been concerned about persistent thoughts of suicide?

What are your goals in seeking psychotherapy?

Do I have permission to contact your PCP or other current or former clinicians who have treated you ONLY AS IT PERTAINS TO YOUR TREATMENT HERE?

Yes

No

Client's Signature*: _____

*Please initial here to acknowledge that your signature will act as an "on file" signature only to be used for filing insurance claims ____.