Name:_____ **Date:**_____

Date of Birth:_____ **Social Security Number (SSN):**_____

Address:_____

_____

_____

Phone:_____

Email:_____

Ok to leave message? Phone: yes no **Text:** yes no **Email:** yes no

Gender:_____ **Sexual Orientation:**_____

Race/Ethnicity:_____ **Preferred Pronouns:** _____

Marital/Partnered status:_____

Children? Yes No
If yes, names and ages:_____

Emergency Contact

NOTICE: The person you identify as your emergency contact is someone Jennie Hagen, LMHC, LPC, can contact in order to coordinate your care in case of psychological crisis or emergency. You will be informed of the intent to contact if the need arises.**

Emergency contact: Name: _____ **Relationship:**_____

Phone:_____

Jennie Hagen, LMHC, LPC
101 East 8th St, Suite 110 • Vancouver, WA 98660
(503) 622-9140 • www.hagencounseling.com • jenniehagenlpc@gmail.com

Medical Information

Primary Care Provider's name:_____ **Phone:**_____

Are you being treated for any medical conditions or concerns? _____

_____

When was your last check-up?_____

Please list any medications or supplements you are taking:

Insurance Information

Insurance Provider:_____

Policy or ID Number:_____ **Group Number:** _____

Insurance companies vary in the confidential information they require in order to pay for services. In addition to information regarding diagnosis and dates of service, some insurance providers will request treatment plans, progress reports, or session notes.

By signing below, I authorize the release of any medical or other information necessary to process a claim to my insurance company. I also request payment of any government benefits either to myself or to the party who accepts assignment. I authorize payment of benefits to Jennie Hagen, LMHC, LPC

_____ _____

Client Signature Date

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In your own words, please explain why you are seeking therapy at this time:

Please check any of the symptoms you have experienced in the last 6 months:

- ❑ Depression
- ❑ Extreme sadness
- ❑ Trouble concentrating
- ❑ Memory problems
- ❑ Change in eating habits or appetite
- ❑ Feeling of extreme happiness
- ❑ Trouble performing in work, school, or other roles
- ❑ Perfectionism
- ❑ Self-Esteem problems
- ❑ Obsessions or compulsions
- ❑ Feeling fearful
- ❑ Physical pain
- ❑ Anger
- ❑ Thoughts about hurting yourself or someone else
- ❑ Feeling hopeless
- ❑ Feeling tearful
- ❑ Sleeping too much or too little
- ❑ Lack of energy
- ❑ Hearing or seeing things that others don't hear or see
- ❑ Weight changes (outside of intentional efforts)
- ❑ Problems in relationships with friends or family
- ❑ Feeling stressed
- ❑ Easily irritated
- ❑ Feeling guilty
- ❑ Feeling nervous
- ❑ Sudden feelings of panic
- ❑ Muscle tension
- ❑ Acting violently
- ❑ Thoughts of killing yourself or others
- ❑ Lack of interest in activities

Clinician use only

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Are there any special, unusual, or traumatic circumstances in your life history? (ex: abuse, neglect, violence, and/or assault, natural disasters)	Y	N
Have you ever experienced family violence, either as a perpetrator, victim, or witness?	Y	N
Have you ever seen a mental health provider before?	Y	N
Is there anyone in your immediate family (parents, siblings, grandparents, aunts/uncles, cousins) with a history of mental health issues, including substance abuse?	Y	N
Do you currently have, or in the past couple of weeks have you had, thoughts or feelings about ending your life?	Y	N
Have you felt hopeless lately, like things wouldn't improve or get better?	Y	N
Have you **ever** attempted suicide?	Y	N
Do you have any health-related concerns that you are not currently being treated for?	Y	N
Have you ever been in legal trouble as a result of drinking or substance use?	Y	N
Do you think your use of alcohol and/or drugs is interfering with your social relationships, job performance, family life, school, work, and/or other responsibilities?	Y	N
Has anyone ever thought you should reduce or stop your use of substances?	Y	N
Has there ever been a time when people either thought you were too thin or were losing too much weight?	Y	N
Have you ever felt out of control and gone on eating binges during which you ate an abnormally large amount of food?	Y	N
Has there ever been a time, lasting at least a few days, during which you felt hyper, charged up with energy, or very high and you felt this was significantly different from your usual self?	Y	N

If your life was as you want it to be, what would be different?

How did you first learn about my services?

Is there anything else you would like me to know as we begin working together? _____

_____

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