DEBRA M. DALBY, L.C.S.W.
208 South King Street, SW #202
Leesburg, Virginia 20175

CLIENT INFORMATION

Date: ___________________

Name:____ Home Phone #:___________________

Address: ____ Work Phone #:_____________________

____ Cell Phone #: ____________________

____ SS#: ____________________________

Marital Status: ___Married ___Single ___Divorced Date of Birth: ___________________

Gender: ___M ___F Age: ______

Employer: ____ Occupation: ____________________

Employer Address: _________________________________

____

Referred by:

_____Physician/Psychiatrist/Therapist (name)____

______Insurance Company ____Internet ______School System ____EAP

______Friend ___ Discharge Plan _____Other:___________________________

GUARDIAN INFORMATION (if applicable)

Guardian Name: __________________________________ Home Phone #:__________________

Address:____ Work Phone #:__________________

____

EMERGENCY CONTACT INFORMATION

Name: ____ Home Phone #: ___________________

Relationship to client: ____________________________ Cell Phone #: ___________________

I, the undersigned, verify that the above information is true and correct.

Signature of Client: ________________________________ Date:________________

Signature of Guarantor: _____________________________ Date:________________

Form: 05/05/2017

Please provide a brief description for your visit:
____
____
____

Please list all others who live in your household:

Name	Age	Relationship to Client

Please list any other immediate family members who do not live in your household:

Name	Age	Relationship to Client

Medical Information

Primary Care Physician: ____
Date of last physical exam: ____
Please list and describe any current medical conditions for which you are receiving treatment:

Please list and describe any significant medical conditions for which you have previously received treatment:

Please indicate the following information on any current medications you are taking:

Name of medication	Dosage	Frequency	Prescribed for

Mental Health Information

Previous Counseling: Yes / No
If so, please provide when and reason for treatment: ________________
____

Please list previous providers: __________________________________
Have you ever been diagnosed with a mental health issue? Yes / No
If so, when and what issue? _____________________________________
____

Are you aware of any history of mental health issues in your family? Yes / No
If so, please describe: ____
____
Do you experience sleep difficulties? Yes / No
If so, please explain: ____
Are you experiencing changes in your appetite? Yes / No
If so, please explain: ____
Are you experiencing significant weight loss or gain? Yes / No
If so, please explain: ____
Have you ever performed acts of self-harm or have thoughts of self-harm? Yes / No
Have you had recent thoughts doing harm to others? Yes/ No
Are there weapons in your home? Yes / No
Do you experience unresolved conflict in your relationships? Yes / No
If so, in what domain? family / intimate / social / school / work
Have you ever felt threatened: physically, emotionally, or sexually? Yes / No

Substance Use

Please describe your typical alcohol intake: ____
Please describe your experience with recreational drugs: ______________________________
Have you/any members of your family suffered from an alcohol/drug addiction? Yes / No
If so, please provide relationship and type of addiction: _______________________________

How often do you experience the following symptoms?

Symptoms:	**Severity**			**Duration**
Anxiety:	Mild	Moderate	Severe	___________________________
Anger:	Mild	Moderate	Severe	___________________________
Depression:	Mild	Moderate	Severe	___________________________
Conduct Problems:	Mild	Moderate	Severe	___________________________
Relationship Difficulties	Mild	Moderate	Severe	

Other:
____

I, the undersigned, verify that the above information is true and correct.
____
Signature Date

Form: 05/05/2017