ENRICA THOMAS, LMFT

Creating New Beginnings Together

CLIENT INFORMATION

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years) and DOB:

____ DOB:___________
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: _____________ Gender: ________________

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list Spouse/Partner's Name: ____

Please list any children/age: ____

____

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

****

EMERGENCY CONTACT

Name: ____

Address: ____

Phone: ( ) ____

By providing this emergency contact, I hereby grant permission for Enrica Thomas, LMFT to contact this individual in the event she feels I am a danger to myself, a danger to others, or am in need of medical assistance.

4815 N. Preston Hwy #6
Shepherdsville, KY 40165
T (502) 200-4992 F (888) 972-4081
askenrica@enricathomas.com

Referred by (if any): ____

JOINT CUSTODIAL OR NONCUSTODIAL PARENT

PARENT____ DOB ___________________
Street Address: ____
City: ______________________________________ State: ________ Zip: ______________________
Primary Phone Number (   ) _____________________ May I leave a message at this number? ______
Email address: _________________________________ May I contact you by email? _______________

PARENT ____ DOB _________________
Street Address: ____
City: ____ State: _________ Zip: ________________
Primary Phone Number: (   ) _____________________May I leave a message at this number? _____
Email address: __________________________________ May I contact you by email?______________
Is there a current court order restricting contact or parent rights?: _______________________________
If so, a copy of the court order is needed for the child's chart.
****

INSURANCE OR EAP INFORMATION

If private pay and no insurance----check here __________
Insurance Provider________________________________ ID# ______________________________
Subscriber's Name: ________________________________ Relationship to Subscriber:______________
Subscriber's SSN: _________________________________ Subscriber's DOB: ___________________
EAP Authorization # ______________________________________ (if applicable)
Responsible Party Name: ____________________________ Relationship to client: _________________
Responsible Party Address: ____
****
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication?

□ Yes
□ No

Please list: ____
____

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Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in ___________________________________

4. Please list any difficulties you experience with your appetite or eating patterns

____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _________________________

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? ____________________________

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7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe ____________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? Are you in school? □ No □ Yes

If yes, what is your current occupation and employer or what grade are you in and what school do you attend?

____

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2. Do you enjoy your work/school? □ No □ Yes Is there anything stressful about your current work/school?

____

____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

____

____

4. What do you consider to be some of your strengths?

____

____

____

5. What would you like to accomplish in therapy?

____

____

____

I certify that I have answered the above questions honestly, accurately and to the best of my ability.

_______________________________ _____________________

Name Date

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