

# Client Information

Date: \_\_\_\_\_

## A. Identification Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ Apt.: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer / School: \_\_\_\_\_ Occupation / Studying: \_\_\_\_\_

## B. Referral Information

Who gave you my name to call? \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

## C. Insurance Information

Your relationship to insured?  Self  Spouse  Child  Other

Insured's Name (if not Self) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_ Insurance ID # \_\_\_\_\_ Policy Group # \_\_\_\_\_

Employer / School \_\_\_\_\_ Insurance Plan Name: \_\_\_\_\_

## D. Family Information

Relationship Status:  Single  Married  Partnered  Divorced  Widow / Widower

This is my  1st  2nd  3rd  4th marriage / partnership.

Number of children and their ages: \_\_\_\_\_

Were your parents  divorced  never married  still married  widowed?

Where are you in the birth order of siblings in your family? \_\_\_\_\_

Family history of:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Depression                             | <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> Anxiety                     |
| <input type="checkbox"/> Eating Disorders                       | <input type="checkbox"/> Mental Illness   | <input type="checkbox"/> Violence                    |
| <input type="checkbox"/> Sexual Abuse                           | <input type="checkbox"/> Emotional Abuse  | <input type="checkbox"/> Alcoholism / Drug Addiction |
| <input type="checkbox"/> Chronic Illness (please explain) _____ |   |  |
| <input type="checkbox"/> Other _____                            |   |  |

	First Name	Current Age or Age at Death	Illness (Cause of Death)	Education	Occupation
Father					
Mother					
Step Parent(s)					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					

**E. Medical Information**

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Exam: \_\_\_\_\_

Major (or chronic) Operations / Illnesses / Injuries \_\_\_\_\_

Current Medications	Dosage(s)	Frequency	Effectiveness	Prescribing Physician

Have you experienced any recent changes in:

- Sleep    Nightmares    Amount of Exercise    Sexual Desire    Eating /Appetite    Weight

How would you characterize your overall health?

- Poor    Fair    Good    Excellent

Do you smoke?  Yes  No   Smoke in the past?  Yes  No   Packs / Day \_\_\_\_\_   Began at what age? \_\_\_\_\_   When did you quit? \_\_\_\_\_

Do you consume any alcohol?  Yes /  No    Less than 1x / mo    1-3x / mo    1x / week    Several x's / week    Every day  
 Beer    Wine    Hard Liquor (check all that apply)

Do you use any street drugs or misuse prescription drugs?  Yes /  No

Names of Drug(s)	Frequency of Use	Names of Drug(s)	Frequency of Use

**F. Treatment Information**

Please describe the main concern(s) that have prompted you to see me now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How have these concerns evolved over time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate your major life stressors of the past 12 months?

- Serious Illness or Injury       Death of a Close Friend or Family Member       Major Illness in Family  
 Gain of New Family Member       Divorce / Separation       Job Change  
 Other \_\_\_\_\_

Please describe what you would like to be different in your life when you are done with therapy?  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever received psychological or psychiatric counseling before?       Yes /  No

When?	From Whom?	Purpose?	Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been prescribed medication for a psychiatric or emotional problem?       Yes /  No

When?	Prescribing Clinician?	What Medication?	For What?	Results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been hospitalized for a psychiatric or emotional health reason?       Yes /  No

When?	Where?	For What Reason?	Outcome?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been in a drug or alcohol treatment program?       Yes /  No       Inpatient       Outpatient

Where?	How long?	Outcome?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**G. Social / Relationship Information**

Please indicate any of the following that you have experienced?

- Death of Mother                      Your age at occurrence \_\_\_\_\_
- Death of Father                      Your age at occurrence \_\_\_\_\_
- Death of Child                      Your age at occurrence \_\_\_\_\_    Child's Age \_\_\_\_\_
- Death of Sibling                      Your age at occurrence \_\_\_\_\_    Sibling's Age \_\_\_\_\_
- Desertion by mother as a child      Your age at occurrence \_\_\_\_\_
- Desertion by father as a child      Your age at occurrence \_\_\_\_\_
- Divorce of parents                      Your age at occurrence \_\_\_\_\_
- Sexual abuse                               Emotional abuse                       Physical abuse
- Violence in the family                       Mental illness of a family member

How do you get along with your present spouse or partner? \_\_\_\_\_

How do you get along with your children? \_\_\_\_\_

How do (did) you get along with your family of origin members?

Mother? \_\_\_\_\_

Father? \_\_\_\_\_

Siblings? \_\_\_\_\_

Please list the first names of your significant friends and indicate how long you have had these relationships?

First name	How long?	How often do you see this person?
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\_\_\_\_\_

\_\_\_\_\_

**H. Employment Information**

What is the nature of your employment? \_\_\_\_\_ How long at current job? \_\_\_\_\_

How satisfied are you in this job?     Not very satisfied     Somewhat satisfied     Comfortable     Very satisfied

Are you satisfied that the income from your job adequately covers your living expenses?

- Not very satisfied     Somewhat satisfied     Comfortable     Very satisfied

Do you have other sources of income?     Yes /  No    Please describe: \_\_\_\_\_

\_\_\_\_\_

**I. Spiritual Resources**

How significant a role does spirituality play in your life?     None     Somewhat important     Significant     Very significant

**J. Other**

Is there anything else you think I should know about prior to our beginning your treatment?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Robyn Howisey, MA, LMFT**

Counseling for Children, Teens & Adults

2319 N. 45th Street #101  
Seattle WA 98103  
206.851.8276

www.thriving-child.com

## Acknowledgement and Authorization

CLIENT NAME: (printed) \_\_\_\_\_ TODAYS DATE: \_\_\_\_\_

### Disclosure Statement:

As shown by my signature below, I have read and understand the Disclosure Statement (v11). This includes understanding and agreeing to the exceptions to confidentiality, the 48 hour cancellation policy, and that the current rate is \$110 per 50 minute session.

I acknowledge a copy has been made available to me at: <http://www.thriving-child.com/forms.html> and is also available in hardcopy form from Robyn Howisey, LMFT by request.

Client Signature: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

### Notice of Privacy Practices:

I hereby acknowledge receiving a copy of the Notice of Privacy Practices (v1).

I acknowledge a copy has been made available to me at: <http://www.thriving-child.com/forms.html> and also is available in hardcopy form from Robyn Howisey, LMFT by request.

Client Signature: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

### Insurance:

If you have Premera, Lifewise, or Blue Cross/Blue Shield and Robyn Howisey, LMFT will be billing your insurance company, please sign below:

I authorize the release of any medical or other information necessary to process all claims. I also request payment of benefits to the party who accepts assignment [Robyn Howisey, LMFT/Thriving Child, LLC].

Client or Authorized person's signature: \_\_\_\_\_



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## Credit Card Payment Authorization

Please enter your credit/debit card information. **Please complete this form even if you will be using insurance.** This card will be charged for co-pays (if you wish), no shows and late cancels, as well as services not covered by insurance.

**Client Name:** \_\_\_\_\_

### Card Holder Information associated with credit/debit card:

Card Holder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email where you wish statements/receipts to be sent:

\_\_\_\_\_

### Credit/Debit Card Information:

Card Type: Visa MC Discover

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please note the vendor will read "Therapy Partner" on your credit/debit card statements. Statements are automatically emailed on the 5<sup>th</sup> of the following month from Therapy Partner and can be submitted to your insurance if applicable.

## Directions to Wallingford Office for Robyn Howisey, MA, LMFT

### Wallingford Work Spaces

2319 N. 45<sup>th</sup> Street

#101 (please wait in the waiting room #114)

Seattle, WA 98103

206.851.8276

### **Driving Directions:**

From I-5 North or South take the NE 45<sup>th</sup> Street Exit (Exit 169). Head West on 45<sup>th</sup>. After a few blocks (past Dick's burgers) turn left onto Sunnyside Ave N. Wallingford Work Spaces are on Sunnyside, just behind the building on the corner of 45<sup>th</sup> and Sunnyside.

### **Parking:**

There is 1 hour parking along 45<sup>th</sup>, and ample residential parking along Sunnyside, 44<sup>th</sup> and throughout the neighborhood behind Wallingford Work Spaces. **Please be aware there is no parking on Sunnyside after 5pm – signs are posted.**

### **Entering the Building:**

Wallingford Work Spaces are just behind (south of) the Loski apartment building. From Sunnyside, go up the stairs between the two brown buildings with red trim. To the left you will see a sliding glass door and "Wallingford Workspace Waiting Room" sign. Please wait in the waiting room and I will come get you at the time of your session.

If your appointment is after 7 pm the building may be locked. Please check the waiting room first. If the waiting room is locked, use the keypad at the exterior door on Sunnyside - search Howisey. Please note, if you are more than 10 minutes early for your session, I may still be in session and not able to buzz you in immediately. Once buzzed in, go up the stairs to the first floor. The waiting room is down the hall to the right, #114.