DAWN DICKSON PSYCHOTHERAPY

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New Client Information Form

Name: _____ Date: _____

Address: _____ City _____ Zip_____

Date of Birth _____

Gender Preference and Preferred Pronoun _____

Home Phone: _____ Okay to leave messages? Y or N

Cell Phone _____ Okay to leave messages? Y or N Okay to text? Y or N

Email Address: _____

Emergency Contact Person: _____Relationship: _____

Contact Person Phone Number: _____

Your Occupation and Employer: _____

If student, school and area of study: _____

Referred by: _____

May I contact this person? Y or N; Contact information: _____

Relationship Status (circle): Single Married Partnered/Significant Other

Separated Divorced Widowed

Name of spouse or Partner _____

Names of children and their ages: _____

<u>Family History</u> (Please circle Yes or No)

Depression	**Y or N**	**Anxiety**	**Y or N**	**Bipolar**	**Y or N**
Alcoholism	**Y or N**	**Drug Abuse**	**Y or N**	**Suicide**	**Y or N**
Psychosis	**Y or N**	**Adoption**	**Y or N**	**Eating Disorder**	**Y or N**
Domestic Violence	**Y or N**	**Frequent Moves**	**Y or N**	**Homelessness**	**Y or N**

Other illnesses, diseases, or mental disorders in family history:

_____

_____

<u>Medical Information</u>

Name, phone number, and address of physician or treating psychiatrist:

_____

_____

Current or chronic health problems (specify): _____

_____

Major operations or injuries (specify and state year):_____

_____

Additional Health Information: _____

_____

Current or Recent Medications (Medication, Dosage, Frequency, Prescriber):

Are you suicidal or do you have suicidal thoughts? Y or N If yes, please describe:

Have you ever attempted suicide? Y or N If yes, please describe:

Do you have homicidal thoughts or thoughts of harming others? Y or N If yes, please describes:

Alcohol Abuse: Do you have problems with alcohol? Y or N If yes, please describe:

Drug Abuse: Do you have problems with drugs (prescription or recreational)? Y or N If yes, describe:

Treatment Information

Have you had previous counseling, psychotherapy, or treatment by a psychiatrist? Y or N If yes, please briefly describe. _____

What brings you to psychotherapy at this time? _____

What would you like to be different in your life or within yourself when you are finished with psychotherapy? _____

What other information would you like me to know before we begin? _____

<u>Insurance Information</u>

Insurance Company: _____

Insured's name (if other than yourself): _____

Insured's date of birth: _____

Member ID: _____ Group # _____

Do you give Dawn Dickson, MSW, LICSW permission to bill your insurance? Y or N

I authorize the release of any medical or other necessary information to process claims with my insurance company. I hereby assign payment of any insurance benefits directly to Dawn Dickson, MSW, LICSW, and I understand that the payment for services not allowed/reimbursed by my insurance company (e.g. deductibles, co-pays, co-insurance, non-coverage) is ultimately my responsibility. I also understand that while infrequent, insurance companies may ask for information from my medical record to insure continued coverage. Dawn Dickson, MSW, LICSW will discuss this with me before submitting any information to the insurance company.

I also authorize Dawn Dickson< MSW, LICSW to release and obtain pertinent medical or psychological information from my treating physician or psychiatrist listed above.

Print Name: _____

Signature: _____ Date: _____