

**Giselle Macfarlane Psychotherapy PLLC**

710 Ericksen Ave NE Suite #100, Bainbridge Island, WA 98110

206 947 6087

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**CONFIDENTIAL CLIENT INFORMATION & HISTORY FORM**

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

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Are you comfortable being contacted by Email? \_\_\_\_\_ Phone? \_\_\_\_\_ Text? \_\_\_\_\_

**Electronic Communication:** I understand the risk inherent in text or email communication. If I provide my email and text number; I authorize Giselle Macfarlane, MA, LMFT to communicate with me as needed about Protected Health Information in these ways. This authorization may be revoked in writing at any time.

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

Client(s)/Parent/Guardian Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Client(s)/Parent/Guardian Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Education: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Occupation: \_\_\_\_\_ Family Income: \_\_\_\_\_

Please check: Single \_\_\_\_\_; Living with partner \_\_\_\_\_ (# of years \_\_\_\_\_); Married \_\_\_\_\_ (# of years \_\_\_\_\_);

Divorced \_\_\_\_\_ (# of years \_\_\_\_\_); Separated \_\_\_\_\_ (How long? \_\_\_\_\_)

Children's Names and Ages (if applicable): \_\_\_\_\_

Names and Ages of People Living in the Home: \_\_\_\_\_

In case of emergency, partner or nearest relative's name, address, and phone: \_\_\_\_\_

If client is under age 13, provide information on parent(s) or guardian(s):

Name(s): \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Primary-Care Physician Name: \_\_\_\_\_

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

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

May I please contact your physician so as to coordinate your care? \_\_\_\_ Y \_\_\_\_ N

What medical problems or illness do you have? \_\_\_\_\_

Current Prescribed Medications: \_\_\_\_\_

Purpose & Side Effects: \_\_\_\_\_

### HISTORY OF THE PRESENTING PROBLEM

What brings you to counseling at this time? Please describe the problem(s) \_\_\_\_\_

When did this problem start? \_\_\_\_\_

How often does this problem occur? \_\_\_\_\_

What areas of your life is this problem affecting? \_\_\_\_\_

What things have you done to try to solve the problem? \_\_\_\_\_

Presence and severity of current symptoms/behaviors: \_\_\_\_\_

PLEASE CHECK BEHAVIORS & SYMPTOMS YOU CURRENTLY EXPERIENCE

<input type="checkbox"/> Aggression	<input type="checkbox"/> Anger	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Body Dysmorphia	<input type="checkbox"/> Daydreaming	<input type="checkbox"/> Self-harm
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Compulsive Behavior	<input type="checkbox"/> Concentration Difficulty
<input type="checkbox"/> Cyber Addiction	<input type="checkbox"/> Depression	<input type="checkbox"/> Disorientation
<input type="checkbox"/> Distractibility	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Drug/ Alcohol Problems
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Grief	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Irritability	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Obsessive Thoughts
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Phobias/Fears	<input type="checkbox"/> Poor Judgment
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Sexual Difficulties	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Social Withdrawal	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Thoughts Disorganized
<input type="checkbox"/> Worrying	<input type="checkbox"/> Fear of Harm	<input type="checkbox"/> other: _____

ALCOHOL & SUBSTANCE USE

Please note the substance, amount, and frequency (“3 beers a day”) of use for the following substances.

Caffeine (ie coffee, tea, soda, energy drinks): \_\_\_\_\_

Cigarettes or chewing tobacco: \_\_\_\_\_

Alcohol: \_\_\_\_\_

Drugs: \_\_\_\_\_

Has your substance use changed recently? If so, how? \_\_\_\_\_

Have you ever been treated for substance abuse and/or regularly attended AA/NA?  Yes  No

Have you ever been treated for alcohol or substance abuse?  Yes  No

Have you ever visited a counselor/psychotherapist before?  Yes  No

For how long? \_\_\_\_\_ Was it helpful? \_\_\_\_\_

With whom? \_\_\_\_\_

Who referred you to me? \_\_\_\_\_

Please fill out the following if you would like to use your Visa or Mastercard or debit for payment. Please note your billing statement will say Giselle Macfarlane Psychotherapy PLLC. Your card will be charged the day of your appointment.

Check one: Visa \_\_\_\_\_ M/C \_\_\_\_\_ Debit \_\_\_\_\_

CARD # \_\_\_\_\_ EXPIRATION Date: \_\_\_\_\_

Security 3-digit CCV code on back of card: \_\_\_\_\_

Name on card: \_\_\_\_\_

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

ZIP CODE associated with the card: \_\_\_\_\_

Sessions & Fees: Therapy sessions usually last 50 minutes. Your fee will be: \_\_\_\_\_

Cancellations within 48 hours will be billed at the full rate. I (we) understand and agree to these conditions.

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

Client(s)/Parent/Guardian Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Client(s)/Parent/Guardian Signed: \_\_\_\_\_ Date: \_\_\_\_\_