Giselle Macfarlane Psychotherapy PLLC
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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?_____

Electronic Communication: I understand the risk inherent in email communication. If I provide my email; 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: _____ Cell Phone:_____

Primary-Care Physician Name:_____

Address:_____

Phone:_____

May I please contact your physician so as to coordinate your care if needed ? ____ 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 therapy 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

___Aggression	___Anger	___Anxiety
___Body Dysmorphia	___Daydreaming	___Self-harm
___Chronic Pain	___Compulsive Behavior	___Concentration Difficulty
___Cyber Addiction	___Depression	___Disorientation
___Distractibility	___Dizziness	___Drug/Alcohol Problems
___Eating Disorder	___Fatigue	___Flashbacks
___Grief	___Hallucinations	___Heart Palpitations
___High Blood Pressure	___Hopelessness	___Hyperactivity
___Impulsivity	___Irritability	___Loneliness
___Memory Impairment	___Mood Swings	___Obsessive Thoughts
___Panic Attacks	___Phobias/Fears	___Poor Judgment
___Low Self-Esteem	___Sexual Difficulties	___Sleep Problems
___Social Withdrawal	___Suicidal Thoughts	___Thoughts Disorganized
___Worrying	___ Fear of Harm	___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, vaping, chewing tobacco:_____

Alcohol:_____

Drugs:_____

Has your substance use changed recently? If so, how?_____

Have you ever been treated for alcohol/substance misuse and/or regularly attended AA/NA? ____Yes ____No

Describe your device and screen use:_____

What is your average daily use:_____

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 60 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:_____