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www.McAllisterTherapy.com / michelle@McAllisterTherapy.com

Date: ____________________

ADULT CLIENT BACKGROUND INFORMATION

Last Name: _________________________ First Name: ________________________ MI: ____

DOB: ___/___/___ Age: ____ Sex: ☐M ☐F Ethnicity _________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other: _________
Number of years married to current spouse: _____ Number of times married: _________

Address: _________________________ City: __________________ State: ____ Zip: _______

Cell Phone:________________ Work Phone:________________ Home Phone:_____________

E-mail____

Check if we can leave a message on your:☐Cell phone ☐Work voicemail ☐Home Phone ☐ Work receptionist

EMERGENCY CONTACT
Last Name: _________________________ First Name: _________________________ MI: ___

Address: _________________________ City: ____________________ State: ____ Zip: ______

Cell Phone: _____________ Work/Other Phone: _____________ Relationship: ____________

HEALTH CARE RESOURCES

☐Check if you don't have health insurance or don't want to use insurance

Provider: _________________My usual office visit copay: ___ (note: this may not be your copay for behavioral health)

Policy/Medicaid Number: ___________________ Group Number: ___________________

Policy Holder (cite name as is appears on the insurance card): _____________________________

Policy Holder Date of Birth ___________________________

Policy Holder Place of Employment: _____________________
Do you have a secondary insurance? ☐ Yes ☐ No (*Note: I cannot bill insurance if you have a secondary)
Any other insurance information____

Combined household income before taxes: _________ Number of people supported on that income: _______

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one): ☐Alone ☐w/ spouse ☐w/Significant Other ☐w/ roommates ☐ w/ family of origin
☐ other: (explain) __________________Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _________________, First ___________________________, Age __ ☐ Male ☐ Female

Last Name: _________________, First ___________________________, Age __ ☐ Male ☐ Female

Last Name: _________________, First ___________________________, Age __ ☐ Male ☐ Female

OTHER PEOPLE LIVING IN HOME (use back if needed)

Name: _______________________________ Relationship to Client: ______________________

Name: _______________________________ Relationship to Client: ______________________

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: ________________, First ______________________, Age __ ☐ Male ☐ Female

City & State ____________________ If minor, with whom _________________________

Last Name: ________________, First ______________________, Age __ ☐ Male ☐ Female

City & State ____________________ If minor, with whom _________________________

FAMILY OF ORIGIN:
Check all that apply to your childhood: ☐ My parents fought a lot ☐ parents got divorced/separated
☐ I witnessed domestic violence ☐ I was adopted ☐ I was removed from my parents' care

Please describe your living situation as a child, noting anything you would want your therapist to know (e.g., parents' marital status, number of siblings, number of stepsiblings/step-parents, with whom you lived, number of times moved, and any other family or origin information you think would be important to list):

____

____

CURRENT RELIGIOUS PRACTICE:
My faith system (aka religious practice) is important to me ☐ Yes ☐ No
If yes, what is your faith system? ____________________
I am an active participant in a place of worship ☐ Yes ☐ No

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

How did you hear about Michelle McAllister? ____

Please write a couple of sentences concerning the reason for your request of services.

____

____

Please check your employment status ☐ Full-time ☐Part-Time ☐Unemployed ☐Not in Labor Force

If employed, who is your employer?

____

What is the highest level of education you have received?_______________________________

In the past 60 days, how many days have you been absent from school/work? ______

Have you served in the military? ____ If so what is your current status? ____________________

Are you currently receiving any government assistance? ____ If so, what programs? ___________

Please check all that apply ☐ Medicaid ☐ Medicare ☐ SSI ☐ SSDI

Are you currently using tobacco products? ___ If so, what type? _____________________

How many times do you use tobacco in a typical day?______________________________

Are you currently using alcohol? ___ If so, please describe your use. _______________________

Are you currently using other substances? ___ If so, please describe your use. ________________

How many times have you been in jail in the past 30 days?__________ 12 months?___________

Have you ever experienced (check all that apply): ☐ Physical Abuse, ☐ Emotional / Verbal Abuse,
☐ Sexual Abuse / Molestation / Sexual Misconduct, ☐ Neglect, ☐ I would rather not answer these

Have you ever attempted suicide? ☐ YES or ☐ NO
If "yes," identify month & year of attempt(s) ______________________________________

Have you ever had thoughts of suicide? ☐ YES or ☐ NO
If "yes," identify month & year of latest thought(s) ____________________________
May I ask about these attempts/thoughts during session with your spouse in the room? ☐ YES or ☐ NO

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐ No

If yes, describe: ____

Physician Name: ____________________ Phone: ____________Address: ________________________________

Are you currently taking medications for mental health? ☐ Yes ☐ No

Are you currently taking medications for physical health? ☐ Yes ☐ No

If yes, list those you are currently taking (use back if needed):

Medication	Strength / Dosage	Length Taken	Purpose	Side Effects You Have Experienced

Please list any allergies:____

Females: Total # of pregnancies: __ Total # of live births: _Type of Pregnancy loss (if you want to share) ________

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No
If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis

* i.e., out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis

Please include any other information you feel is important for your therapist to know.

____

____

____

____

For office use:

_________________________ _______________ _____________________
Client name Case number Family name

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