CHOICES to CHANGE

Date_____

Name _____

First Middle Last Suffix

Address _____

_____

Number where you would like to be reached: _____

Email (scheduling only):_____

Emergency Contact (name and number): _____

Date of Birth: _____

Gender: Male Female Transgender Prefer not to answer

Ethnicity: _____

Sexual Orientation: Heterosexual Gay Lesbian Bisexual Other _____

Marital Status: Single Married Separated Divorced

Occupation_____

Employer_____

Insurance Company_____

Subscriber ID_____ Subscriber Name_____

Group ID# _____

If you wish to use a sliding scale fee, fill out this information:

Net Yearly Income_____

Family Size_____

804.277.9019 www.choicestochangellc.com JBrown@choicestochangellc.com

Clinical Information:

Describe briefly what brings you into therapy: _____

_____

_____

Please check any area of concern that applies:

__Job	___School	___Marriage or Family Concerns	__Relationship
__Health	___Depression	___Anxiety	__Stress
__Career/Vocation	__Spiritual/Faith	___ Eating Concerns	__Sleep
__ Energy	___ Substance Use	__Memory/Concentration	

Please rate your overall physical health: Excellent Good Average Fair Poor

List any health problems you are currently experiencing: _____

_____

List any current medications _____

Please rate your overall level of stress: Low Moderate High

Please any substances you use, and how often: _____

_____

Please check any symptoms you have experienced in the past 2 weeks:

__ Sadness	__Anxiety	__Stress	__Trouble Sleeping
__Poor appetite	__low sex drive	__Worry	__mood swings
__irritability	__loss of pleasure	__trouble concentrating	__ less social
__substance abuse	__headaches	__stomach issues	__numbness/tingling
__guilt	___hopelessness	__ helplessness	__worthlessness
__ self-injury	__thoughts of suicide	__ periods of high energy	__ eating too much