CONFIDENTIAL BACKGROUND INFORMATION

NAME_____ DATE _____

ADDRESS _____

_____

AGE _____ DATE OF BIRTH _____ MARITAL STATUS_____

PHONE HOME _____ WORK _____CELL_____

SOC. SEC. # _____ EDUCATION _____

OCCUPATION _____ EMPLOYER _____

PERSONAL PHYSICIAN _____

MAJOR HEALTH PROBLEMS _____

CURRENT MEDICATIONS _____

IN CASE OF EMERGENCY, NOTIFY_____

TELEPHONE_____

REFERRAL SOURCE _____

BRIEFLY DESCRIBE YOUR REASONS FOR SEEKING SERVICES _____

_____

_____

DATES AND REASONS FOR PREVIOUS MENTAL HEALTH TREATMENT

_____

_____

THANK YOU FOR COMPLETING THIS FORM

I acknowledge receipt of the Psychotherapist-Client Services Agreement and agree to abide by its terms.

Client's Signature _____ Date _____

I acknowledge receipt of the Notice of My Policies and Practices to Protect the Privacy of Your Health Information.

Client's Signature_____ Date _____

Signatures below only for those using insurance:

I authorize the release of any medical or other information necessary to process my insurance claim. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Client's Signature _____ Date _____

I authorize payment of medical benefits to **Carol Twitchell, Psy.D.** for services rendered.

Client's Signature _____ Date _____