Carol J Henry PhD
PSYCHOLOGIST

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Name____

Age________Gender____________

Address______________________________
Street

____Date of Birth_____________
City State Zip

Home Phone_______________Mobile:_________________OK to leave message?______

Employer Information

Employer: _____________________________Occupation:____________________________

Work Phone: ________________________ OK to leave message? ____________

Insurance Information

Name of Subscriber_______________________Subscriber Number_________________

Insurance Company__________________________Group Number__________________

Medical and Referral Information

Name of Physician____________________________ Date of Last Physical ____________

Address____Phone_______________

Medications currently taking and condition they are for:
____

Prescribed by_________________________________Phone_____________________________

Emergency Contact: _______________________________Relationship to you_________

Address____

Best phone _____________________________Alternate phone_____________________

Previous Counseling

Counselor's
Name____Dates______________________

Family

Name(s) and Age(s)

Spouse/partner____

Your children ____

Mother__________________________ Father____________________________

Sisters____

Brothers____

Education

High School ________________________________Date graduated: ________________

College ________________________________Date graduated: ________________

Grad/Prof. School _________________ Degree ________Date graduated____________

Any significant losses in past few years. (Please describe)

Have you or anyone in your family had any of these problems?

	Self	Family	Comments
Alcohol abuse	______	_______	____________________________
Drug abuse	______	_______	____________________________
Heavy smoking	______	_______	____________________________
Obesity	______	_______	____________________________
Eating problems	______	_______	____________________________
Depression	______	_______	____________________________
Anxiety	______	_______	____________________________

Suicidal thoughts, attempts/complete	______	_______	____________________________
Other mental health problems	______	________	____________________________
Domestic violence	______	________	____________________________
Sexual abuse	______	________	____________________________

Other (Please describe):

Any other comments or information:

Major reasons for seeking psychotherapy:

--***Please sign below***--

I have read the OFFICE INFORMATION AND POLICIES disclosure form and agree to the conditions described in that document.

Printed Name ____

Signature ____

Date signed ____

Revised 3-16-14