Anna Zurek, LMFT
145 South Holly Street • Suite B • Medford, OR 97501
Phone: (541) 951-5123 • Email: ThriveWithinCounseling@gmail.com

Client Name:_____Today's Date:_____

Gender: _____ Age:_____ Date of Birth:_____ Social Security #:_____

If Minor, Custodial Parent(s) Name:_____
Parent's Social Security #:_____
HomeAddress:_____
City:_____ State:_____ Zip:_____
Telephone Numbers:_____ _____ _____
(home) (work) (cell)

Initial Yes or No:
May I leave messages for you at home: Yes____No____ At work: Yes ____ No _____
May I Leave messages for you on cell: Yes____No____ On Text: Yes____ No_____
On Email: Yes____No_____ E-mail address: _____

Name of Insurance Company:_____
Subscriber Name:_____ Subscriber D.O.B._____
Subscriber I.D. #:_____Group I.D.#_____
Subscriber Employer:_____
Has yearly deductible been met?_____ co-pay amount:_____

If you have additional insurance coverage, please provide the name, ID# and phone number for secondary insurance: _____
_____

Insurance Fees for service are: $250 for an initial assessment, $90 for a 30-minute session, $129 for a 45-minute session, $160 for a 60-minute individual session, $50 for 15 min case management. I understand that I am ultimately responsible for these fees, and agree to pay any balance not covered, or disallowed by insurance. I further understand, and agree that I will be charged 50% for any missed session that I fail to cancel within 24 hours. I hereby authorize release of any personal information necessary to process my claim, including my diagnosis. I understand that this information may become a permanent part of my insurance records.

_____
Signature of financially responsible party Date

I have read and I understand the Notice of Privacy Practices that was provided to me

_____
Signature of client and/or legal guardian Date

Client Name:_____

PRESENTING PROBLEM

Describe the problem(s) that brought you here today:

_____
_____
_____
_____
_____
_____
_____

Check any of the symptoms that the client has been having:

___Depressed mood
___ Security blanket or object
___Change in eating habits
___Difficulty with school
___Low self-esteem
___Trouble concentrating
___Problems with sleeping
___Feeling fearful
___Tearful/crying spells
___Lack of energy
___Worries
___Stuttering
___Feeling stressed
___Feeling hopeless
___Irritability
___Self harm
___Thumb sucking
___Fire setting
___Obsessions or compulsions
___Sudden feelings of panic
___**Thoughts of killing self***
___**Seeing things that others do not***
___**Other***: _____

___Feeling guilty
___Muscle tension
___Eating problems
___Toileting problems
___Trouble performing job responsibilities
___Perfectionism
___Running Away
___Problems getting along with family
___Anger outbursts
___Difficulty enjoying usual activities
___Bedwetting
___Physical complaints of pain
___School truancy
___Weight/appetite changes
___Memory problems
___Acting violently
___Problems getting along with others
___Feeling of extreme happiness
___Isolation/withdrawal
___Harm to animals
___**Thoughts of killing others***
___**Legal Issues***

***Describe in detail:**

_____
_____
_____
_____
_____
_____
_____

Client Name:_____

PRIOR COUNSELING HISTORY:
Please describe any prior counseling below starting with the most recent first.
Therapist name(s):_____
Details:_____
_____
_____
_____
_____
_____
_____
_____

Current and/or prior psychiatric medication history (include doctor's name):
_____
_____
_____

Name of current medications and dosage(s):
_____
_____
_____

SUBSTANCE USE HISTORY:
CHECK HERE IF N/A _____
Alcohol use ___Current ___Suspected ___Past ___No
Recreational drugs ___Current ___Suspected ___Past ___No
List type of drug used_____

MEDICAL HISTORY:
Was the client seen by a doctor within the last year? ___Yes ___No
Purpose of visit:
_____
_____

Client Primary Care
Provider:_____Phone:_____
Please list any prescription or over-the-counter medications currently being taken:
_____
_____

Please list any major medical problems such as serious illness, operations, injuries or trauma to the head, etc:
_____
_____
_____

Client name: _____

MEDICAL HISTORY (cont.)

List allergies:

_____
_____

Stressful Events: Please describe any history of parental separation, divorce, moves, major accidents, deaths, abuse (physical, sexual or emotional), etc.

_____
_____
_____
_____
_____
_____

FAMILY MENTAL HEALTH SUBSTANCE ABUSE HISTORY:
Please describe and include all extended family usage:

_____
_____
_____
_____
_____
_____
_____

Other Issues:
Please describe any other issues or facts I may need to know for client treatment:

_____
_____
_____
_____
_____

Please describe your goals for therapy:

_____
_____
_____
_____
_____
_____