Intake Date_____ Presenting Diagnosis _____
Office use *Office use*

CHRISTOPHER H. ANDERSON, LCSW - CLIENT REGISTRATION INFORMATION (Please Print)

Please fill out all items below. The items in bold print are required by your insurance company to submit a claim.

Client Information

Client Name _____ **Date of Birth**_____
Address _____ **Social Security #**_____
_____ **Relationship to Insured (Circle One)**
_____ Self Spouse Child Other
Phone (h)_____ **Sex** F _____ M _____
Phone (w) _____ **Marital Status** S___M___D____W____ P ____
Phone (cell)_____ **Student Status** N____ F____P____
Primary Care Physician _____ Employer _____
PCP Address _____ Referred By _____
_____

Insured/Guarantor Information (If the Insured is the Client, fill in only the two boxes below)

Insured's Name _____ **Date of Birth**_____
Address_____ **Social Security #** _____
_____ **Sex** F_____ M_____
_____ **Empoyment Status (Circle One)**
Full Time Part Time Unemployed Retired

Phone (h) _____
Phone (w)_____
Phone (cell)_____

Employer _____ Occupation _____
Insurance Company Name _____ Plan Type _____
Insurance ID# _____ **Group #**_____
Insurance phone # _____ **Employment Status** F ___ P ___ N/A ___

*** If there is other insurance to cover this patient, print information on the back of this form*.

Beneficiary/Guarantor Signature (Initial and Sign)

_____ I request that payment of the authorized insurance, Medicaid, and Medicare benefits be made on my dependents or my behalf to Christopher H. Anderson, LCSW for the services furnished me or my dependents by the provider. I authorize any holder of medical information about my dependents or myself to release to the Centers for Medicare and Medicaid Services and its agents or my insurance company any information needed to determine the benefits payable for related services.

_____I understand that even though Christopher H. Anderson, LCSW or his agent will submit claims to my insurance, I am responsible for the portion of my bill considered to be my insurance co-payment, co-insurance, deductible, or other charges not covered by insurance including non-payment for my failure to comply with insurance guidelines regarding prior authorization of treatment related services. .

_____ **I understand there will be a charge for late cancellation (less than 24 hours) or failure to show for an appointment. This is not covered by insurance.**

X_____ Date _____
Signature of Beneficiary/Guarantor

Name _____ Date_____

Household (list all who live in home – use back if necessary)

Name	*Relationship to Client*	*Date of Birth*

If client is a minor

School		Grade		City	
Father's name		Occupation			
Mother's name		Occupation			
Form completed by		Relationship to child			

In case of emergency

Contact name _____ *Relationship to client* _____

Mobile phone _____ *Home phone* _____ *Work phone* _____

Health information (use back if necessary)

List any current health concerns _____

Current prescribed medications	*Purpose*

If you are currently taking any psychiatric medications, who prescribed them? _____

And in what city or town is their practice located? _____

Previous mental health or substance abuse treatment (including inpatient or outpatient services)

Year of treatment	*Treatment provider*	*Type of treatment*	*Length of treatment*

Please think about what brought you here today.

1. **Mark the check box of <u>one or two</u> problems that are the most troublesome for you.**
2. **On a scale of 0 to 5, please rate how you feel today about <u>each problem</u> in the list**

		No problem									Worst I've ever felt
☐	Depression	0	1	2	3	4	5	6	7	8	9	10
☐	Anxiety/Stress	0	1	2	3	4	5	6	7	8	9	10
☐	Grief/Loss	0	1	2	3	4	5	6	7	8	9	10
☐	Self-Esteem Issues	0	1	2	3	4	5	6	7	8	9	10
☐	Relationship Problems	0	1	2	3	4	5	6	7	8	9	10
☐	Substance Abuse/Addiction	0	1	2	3	4	5	6	7	8	9	10
☐	Anger/Aggression	0	1	2	3	4	5	6	7	8	9	10
	Other (write in here) _____	0	1	2	3	4	5	6	7	8	9	10

Name _____ Date_____

Relationship Conflicts Questionnaire	**Yes**	**No**
1. Do you go along with your partner's request even if you disagree because you're afraid of his/her temper?		
2. Do you often want to rescue your partner when he/she is troubled?		
3. Do you make excuses for yourself or others for your partner's behavior when you have been mistreated?		
4. Are you accused falsely by your partner of having an affair?		
5. Are you hit/punched in places where bruises won't show?		
6. Does your partner try to isolate you or control your choice of friends and activities?		
7. Does your partner threaten to harm you or your children?		
8. Does your partner call you names, kick, shove, punch, choke, cut, burn, spit, or throw things at you when jealous or angry?		
9. Does your partner drink heavily or use drugs?		
10. If your partner abuses drugs or alcohol, are any of the situations above more likely to occur while he/she is drunk or high?		
Drug/Alcohol Questionnaire	**Yes**	**No**
1. Do you have problems at work or school due to drinking or other drug use?		
2. Is drinking or drug use making your home life unhappy?		
3. Do you drink or use other drugs in order to help you feel more comfortable around people?		
4. Is drinking or drug use hurting your reputation?		
5. Has anyone ever suggested to you that you have a drinking or drug problem or that you should go to an Alcoholics Anonymous or Narcotics Anonymous meeting?		
6. Have you been in financial difficulties as a result of drinking or drug use?		
7. Do you to different companions and an inferior environment when drinking or using drugs?		
8. Does your drinking or drug use make you careless of your family's welfare?		
9. Has your motivation decreased since drinking or using drugs?		
10. Do you ever crave a drink or high?		
11. Do you use alcohol or other drugs in the morning?		
12. Do you have difficulty sleeping unless you have a drink or drug first?		
13. Have you been involved in physical or *serious* verbal fights when drinking or using drugs?		
14. Do you drink or use drugs to escape from worries or troubles?		
15. Do you drink or use drugs when you are alone?		
16. Have you ever had a memory loss after a night of drinking or drug use?		
17. Have you ever made promises to cut back or control your drinking or drug use?		
18. Is it difficult to imagine living without alcohol or drugs?		
19. Have you ever been arrested while intoxicated?		
20. Have you ever been hospitalized or taken to an emergency room due to drinking or drug use?		
Trauma Questionnaire	**Yes**	**No**
1. Are there any periods of your childhood or adolescence that you have a particularly hard time remembering?		
2. Did you ever run away from home while growing up? If so, what did you want to get away from?		
3. Are there any events from your childhood about which you felt uncomfortable, that you haven't shared with anyone?		
4. Were there any dramatic changes in your behavior, school performance, or how you felt about yourself as a child or adolescent?		
5. Were there any secrets you had as a child growing up in your family?		
6. Did you ever have any unwanted sexual contact with members of your family? Father? Mother? Stepfather? Stepmother? Uncles? Aunts? Brothers? Sisters?		
7. Were you ever inappropriately approached sexually as a child?		
8. If you are currently involved in a sexual relationship, is it comfortable?		

Beck Depression Inventory

Please choose the best answer for each group

0 I do not feel sad
1 I feel sad
2 I am sad all the time and I can't snap out of it
3 I am so sad or unhappy that I can't stand it

0 I am not particularly discouraged about the future
1 I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel that the future is hopeless and that things cannot improve

0 I do not feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life all I can see is a lot of failures
3 I feel that I am a complete failure as a person

0 I get as much satisfaction out of things as I used to
1 I don't enjoy things the way I used to
2 I don't get real satisfaction out of anything anymore
3 I am dissatisfied and bored of everything

0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel quite guilty most of the time
3 I feel guilty all the time

0 I don't feel I am being punished
1 I feel I may be punished
2 I expect to be punished
3 I feel I am being punished

0 I don't feel disappointed in myself
1 I am disappointed in myself
2 I am disgusted with myself
3 I hate myself

0 I don't feel I am worse than anybody else
1 I am critical of myself for my weaknesses or mistakes
2 I blame myself all the time for my faults
3 I blame myself for everything bad that happens

0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself but I would not carry them out
2 I would like to kill myself
3 I would kill myself if I had the chance

0 I don't cry any more than usual
1 I cry more now than I used to
2 I cry all the time now
3 I used to be able to cry but now I can't even cry even though I want to

0 I am no more irritated by things now than I ever am
1 I am slightly more irritated now than usual
2 I am quite annoyed or irritated a good deal of the time
3 I feel irritated all the time now

0 I have not lost interest in other people
1 I am less interested in other people than I used to be
2 I have lost most of my interest in other people
3 I have lost all of my interest in other people

0 I make decisions about as well as I ever could
1 I put off making decisions more than I used to
2 I have greater difficulty in making decisions than before
3 I can't make decisions any more

0 I don't feel that I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel that there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly

0 I can work about as well as before
1 It takes extra effort to get started at doing anything
2 I have to push myself very hard to do anything
3 I can't do any work at all

0 I can sleep as well as usual
1 I don't sleep as well as I used to
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
3 I wake up several hours earlier than I used to and cannot get back to sleep

0 I don't get more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I am too tired to do anything

0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore

0 I haven't lost much weight, if any, lately
1 I have lost more than five pounds
2 I have lost more than ten pounds
3 I have lost more than fifteen pounds

0 I am no more worried about my health than usual
1 I am worried about physical problems such as aches and pains or upset stomach or constipation
2 I am very worried about physical problems and it's hard to think of much else
3 I am so worried about my physical problems that I can't think of anything else

0 I have not noticed any recent change in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely