Michael R. Allison, MA, LMHC - Psychotherapy Services

2271 NE 51st Street - Seattle, WA 98105
Ph: (206) 522-8553 x-300 Fax: (206) 522-7815

CLIENT INFORMATION

Name(s): ____________________ Date: ____________

Address: ____________________City:____________ State: ____

Zip: ________ Telephone: (H)________________ (W)________________

Cell:______________Email: ________________Date of Birth: __________

Would you like to bill Insurance? (circle one) Yes / No Insurance Co. (circle one): Regence / Premera

Single: _____ Married: _____ Children (names/ages): 1. ________________

2. ________________ 3. ________________

Annual Household Income: $____________ # of dependents: __________

Emergency Contact: name:________________ Tel:________________

Please briefly describe your reason(s) for seeking therapy:

____

____

Who provided the referral to me? ________________________
Have you had previous therapy? __________ Dates:________________

Are you currently taking any psychiatric medications? __________

If yes, please list: ________________Prescribed by: ________________

Have you ever been hospitalized? ________ Date(s): ________________

If so, reason for hospitalization: ________________________.

Primary Care Physician:______________ Tel.:________________

Please list current physical/medical problems: ________________________

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Are you receiving a treatment for any medical problems? Y / N

List medications you are currently taking:

Name of medication	Dosage	Prescribed Physician	Reason Taken

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Please rate your past month experience of the following symptoms
from 0 to 3 (0-none, 1-mild, 2-moderate, 3-severe.)

Depressed Mood		Worthlessness	
Anxiety		Hopelessness	
Suicidal Thoughts		Weight Change	
Homicidal Thoughts		Eating Difficulties	
Panic Attack		Sleep Difficulties	
Anger		Racing Thoughts	
Guilt		Fear	
Tearful/Sadness		Other (Specify)	

Do you drink alcohol? Y / N How much? __________ How often? ___________________ _______

Do you smoke cigarettes/tobacco? Y / N How much? ____ How often? _________________ _____

Do you use caffeine, soda/coffee/tea? Y / N How much? _____ How often? __________________

Have you had any substance abuse or addiction problems? Y / N

Which of these substances do you / have you used recreationally: Rx Drugs_______

___Alcohol ___Cocaine ___Marijuana ___Caffeine ___Opiates __

____Other (specify:______________________________)

Has your alcohol or drug use changed recently?: _________________________ _________________

Have you ever received chemical dependency treatment? Y / N
___ Inpatient ____Outpatient

If yes, Date(s) and length: ____

Additional comments:

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