Client Information

Lynch, Lynch & Norrell 6205 W. Gore Blvd. Lawton, Ok 73505

Today's Date _____

Name: _____ Age: _____ Date of Birth: _____

Gender: ❑ Male ❑ Female SSN # _____

Address: _____
Street City ST Zip

Contact Information: Home # _____ Cell # _____ Work # _____

Spouse /Parent: _____Age: _____ Date of Birth: _____

Spouse/Parent SSN: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated

email Address _____ Preferred Initial Contact : ❑ Home ❑ Cell ❑ Work

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Employment:

Clients Employment: _____ Length of Service: _____

Address: _____ City: _____ St: _____

Spouse's Employment: _____ Length of Service: _____

Insurance Information: PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS AND POLICY INFORMATION

Primary Insurance: _____ ❑ Yours ❑ Spouse's ❑ Parent ❑ Step Parent

Policy # _____ SSN# of Insured _____ Insr. DOB _____

Secondary Insurance: _____ ❑ Yours ❑ Spouse's ❑ Parent ❑ Step Parent

Policy # _____ SSN# of Insured _____ Insur. DOB:_____

Does anyone else possible hold Health Insurance on the Above Named Client ❑ Yes ❑ No

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Emergency Contact: Please list someone and the information who may be contacted in the event of an emergency either day or night. NO clinical information will be given to this person unless necessary to prevent loss of life or safety to self or others.

Name: _____ Relationship: ❑ Spouse ❑ Parent ❑ Friend ❑ Child

First # _____ Second # _____

How did you hear about us or who Refered you to our Office ? _____

Client Information

Physical Health Information:

Primary Care Physician: _____ Last Seen: _____ Number of Years Tx By PCP _____

Allergies: _____, _____ , _____

Surgeries: _____ Chronic Health Issues: _____

Current Medications: Please attache list or list on reverse if needed:

	Name:	Dosage:	Taken For:	Taken Since:
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____

Current & Past Health Tx:

❑ Frequent Colds/Flu	❑ Stomach Problems	❑ Cardiac Problems	
❑ Hypertension	❑ Thyroid	❑ Allergies	❑ OB/GYN
❑ Headaches	❑ Weight loss/ Gain	❑ Infertility	❑ Aborted Pregnancy
❑ Family Mental Hx	❑ Depression	❑ Rape Victim	❑Domestic Violence
❑ Crime Victim	❑ Alcohol Use Last used _____		❑ Drug Use Last Used _____

Mental Health History: Outpatient Treatment Hx. ❑ Yes ❑ No Inpatient Treatment Hx. ❑ Yes ❑ No

When:	Therapist/ MD	Diagnosis / Problem	Helpful?
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No

Current Goal/ Reason / Problem for seeking Treatment:

_____

_____

Who Else Lives in your Home?

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list Additional on the Reverse- Thanks

Concerns Checklist and History

Please mark the items below that apply to your current circumstances and history. Please make a note to anything that you may feel needs further explanation or clarification.

- ❑ Abuse / Physical
- ❑ Abuse/emotional
- ❑ Abuse/sexual
- ❑ Alcohol abuse
- ❑ alcohol dependency
- ❑ anger
- ❑ anxiety
- ❑ attention, concentration
- ❑ career problems
- ❑ childhood issues
- ❑ child management issues
- ❑ codependence
- ❑ confusion
- ❑ custody/children
- ❑ decision problems
- ❑ delusions / false ideas
- ❑ dependence
- ❑ depression
- ❑ divorce / separation
- ❑ drug use
- ❑ eating problems/disorders
- ❑ failure
- ❑ fatigue
- ❑ fears
- ❑ financial problems
- ❑ friendships
- ❑ gambling
- ❑ grief
- ❑ guilt
- ❑ headaches
- ❑ health issues
- ❑ inferiority
- ❑ infertility
- ❑ interpersonal conflicts
- ❑ irresponsibility
- ❑ impulsive behaviors
- ❑ judgment problems
- ❑ legal matters
- ❑ loneliness
- ❑ marital conflict
- ❑ memory problems
- ❑ menstrual problems
- ❑ mood swings
- ❑ motivation
- ❑ nervous tension
- ❑ nightmares
- ❑ obsessive compulsive
- ❑ oversensitive
- ❑ panic attacks
- ❑ perfectionism
- ❑ pessimism
- ❑ procrastination
- ❑ relationship problems
- ❑ risk taking
- ❑ school problems
- ❑ self-centered
- ❑ self-esteem
- ❑ self neglect
- ❑ sexual issues
- ❑ sleep problems- delayed onset
- ❑ sleep problems- early awakening
- ❑ smoking
- ❑ stress
- ❑ suspiciousness
- ❑ suicidal thoughts - past
- ❑ suicidal thoughts - current
- ❑ suicidal attempt
- ❑ temper problems
- ❑ thoughts unorganized
- ❑ threats / violence
- ❑ weight loss
- ❑ weight gain
- ❑ withdrawal / isolation
- ❑ work problems

Childhood: These are issues or concerns that you may have experienced in childhood or may be CURRENT issues for your child or minor that you have sought treatment.

- ❑ bullies
- ❑ bedwetting
- ❑ cheating
- ❑ constant health complaints
- ❑ cruel to animals
- ❑ cries easily
- ❑ difficulty with family
- ❑ developmental delays
- ❑ disrupts family activities
- ❑ disobedient at home
- ❑ disobedient at school
- ❑ distractible
- ❑ dropped out of school
- ❑ drugs or alcohol use
- ❑ family/stepparent issues
- ❑ failure in school
- ❑ fighting
- ❑ fire setting
- ❑ lacks organization
- ❑ lacks respect for authorities
- ❑ learning disability
- ❑ lying
- ❑ mental retardation
- ❑ nail-biting
- ❑ overreactive
- ❑ recent move/loss
- ❑ rocking
- ❑ running away
- ❑ school suspension/expulsion
- ❑ temper tantrums
- ❑ thumb sucking
- ❑ teased / bullied
- ❑ truant
- ❑ uncoordinated

Please indicate weather or not you have discussed your mood or mental health issues or treatment with your primary care provider. ❑ Yes ❑ No

Do you want your primary care provider(s) informed of your treatment and/or it's progress ❑ Yes ❑ No

Do you wish your primary care provider consulted or advised of your symptoms or response to any medication that you have be prescribed for your treatment? ❑ Yes ❑ No