LAUREN ROSE, LCSW, RYT

Please complete this form and bring it to your first session. Please note that all the information you provide is considered confidential.

NAME: _____ **DATE:** _____

Name of Parent/guardian (if under 18): _____

Date of Birth _____/_____/_____ Age: _____ SS# _____

Marital Status: If Married: Wedding Date: _____/_____/_____

□Married □ Divorced □ Separated □ Never Married □ Domestic Partnership □ Widowed

Please list and children/ages: _____

Home Address _____

City_____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____

Email _____

Do I have your permission to call and/or leave messages at: Home ___ Work ___ Cell ___ Email ___

Preferred method of communication: _____

Referred by (if any): _____

Reason for referral _____

Primary care doctor/ Psychiatrist _____

Phone ( ) _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes Please list: _____

□ No

17 Purdy Ave, Rye, NY 10580 914-921-9100
www.rosecenterny.com www.facebook.com/TheRoseCenter
laurenroselcsw@gmail.com

Have you ever been prescribed psychiatric medication?

□ Yes Please list and provide dates: _____

□ No

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns. _____

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No

□ Yes-For approximately how long _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No

□ Yes-When did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

□ No

□ Yes—Please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes—How often_____

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently married, or if single, in a romantic relationship? □ No □ Yes If yes, for how long?___

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently? _____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence/Abuse Victim or witness of physical, sexual or verbal abuse	yes / no	
Eating-Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

SIGNIFICANT FAMILY RELATIONSHIPS: Please list mother, father, past spouses, children, siblings and other significant people in your life. Describe as close, distant, cut off, very close, neither close nor distant.

NAME	RELATIONSHIP TO YOU	AGE	BRIEFLY DESCRIBE RELATIONSHIP

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation:_____
Do you enjoy your work/ Is there anything stressful about your current work?_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes—Describe your faith or belief and its role in your life: _____
3. What do you consider to be some of your strengths? _____
4. What do you consider to be some of your weaknesses? _____
5. What would you like to accomplish out of your time in therapy? Do you have any specific goals?
_____

BILLING: Please complete for person responsible for bill

Name _____ Date of Birth _____/_____/_____
Relationship _____ SS# _____
Home Address_____
City_____ State _____ Zip _____
Home Phone ( )_____ Cell Phone ( )_____
Employer _____
Address_____
City _____ State _____ Zip _____

INSURANCE INFORMATION: If you would like me to submit form to your insurance company, please provide all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for all policies. Please list all numbers on your card(s). This is a service to help you with paperwork. All reimbursement should be directed to you and is between you and your insurance company.

Primary Insurance Company _____ Phone #: _____
Insurance Company Address _____
ID # _____
Subscriber _____ Date of Birth _____/_____/_____
Relationship to Subscriber (check one): Self _____ Spouse _____ Child _____ Other _____
Please provide same information for any additional policies you may have.