1015 14th Street, Suite F
Anacortes, WA 98221
360-899-5816

INITIAL INTERVIEW FORM

CLIENT INFORMATION: **Date:**______________________________

Name:____
Phone: (Wk)_____________________________(Hm)_____________________________________
Address:________________________________City:______________________________________
State:__________________________________Zip:_______________________________________
Sex: Male____________Female____________ Date of Birth:______________________________
Employer:______________________________ Occupation:________________________________
How long have you worked there? __________ How long in this occupation? _______________
Education: (List highest level of education attained) _________________________________
Primary Physician:____________________________ Phone:______________________________
List any significant health problems:____
____
____

List any medications you are taking and the dosage:____________________________________
____

Have you seen this type of therapist before? Yes_____ No_____

If yes, when and with whom? ____

Give a brief description of the treatment:____
____

How were you referred to our office?____

Who may we thank for referring you?____

Nearest relative other than spouse:____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name:_______________________________________Relationship to client:________________

Phone (if different from above):____

Address (if different from above):____

Insurance Carrier (if applicable):____

Employer (if different from above):____

Date of Birth (if different from above):____

Social Security Number of Insured:____

Group Number:_____________________________Member ID:__________________________

Insurance Plan Name:____

Insurance Phone Number:____

Insurance Coverage for Out Patient Mental Health:

Insurance coverage can be confusing, many find it helpful to complete this next section so they are aware of their financial obligations.

Is Mental Health counseling covered under you policy? _________________________________

If yes, is Dion Menser-Andreini an approved provider? ☐ Yes ☐ No

Based on this information, what does your insurance cover for counseling services?

Insurance covers _____% of each session. You are responsible for a **co insurance** of_____%. And/ Or your Co Pay per session is: ________.

Do you have an annual Deductible? ☐ Yes ☐ No

If so, how much of your deductible has it been met this year? ____________________________

Do you need prior approval to receive counseling? If so, from whom? _____________________

When and how did you get this approval? ____

And finally, how many mental health sessions does your plan cover per year? _______________

Family Information:

Circle

Relationship Status: Single Married Partnered Divorced

I am circling that this is my First, Second, Third, Forth, Fifth or Sixth marriage.

Names of my bio and step children and their ages, please put a circle around those children that live with you:____

____

____

How do (did) you get along with your:

Biological Mother?

____

Biological Father?

____

Step Mother?

____

Step Father?

____

Your Siblings?

____

Social connections are important to our health please document your support group. List the first names of your significant friendships and indicate how long you have had each relationship

First name, age, and how close, very close, somewhat close, distant, uncertain and how long you have known this person and how often do you see each of them:

____

____

____

____

____

____

____

____

____

Medical Information:

Primary Care Physician:________________________________ Last Exam:_________________

Allergies:____

Major or Chronic
Operations/Illnesses/Injuries:____
____
____

Current Medications	Dosage(s)	Frequency	Effectiveness

Do you have reactions to any of the Medications?
____

Have you experienced any recent changes in any of the following? Please explain:

☐ Sleep ☐ Nightmares ☐ Amount of Exercise
☐ Sexual Desire ☐ Eating/ Appetite ☐ Weight

How would you characterize your overall health?
☐ Poor ☐ Fair ☐ Good ☐ Excellent

Do you smoke? ☐ Yes ☐ No (Did you smoke in the past? ☐ Yes ☐ No)

Do you consume any alcohol? ☐ Yes ☐ No (Check all that apply)
☐ Less than 1x/ mo ☐ 1-3/ mo ☐ 1x/ week
☐ Several times a week ☐ Every day
☐ Beer ☐ Wine ☐ Hard Liquor

Do you use any street drugs or misuse prescription drugs? ☐ Yes ☐ No
Names of Drug(s):
____
Frequency of Use:
____

Have you ever been in a drug or alcohol treatment program?

☐ Inpatient ☐ Outpatient

Where?

____

How long?

____

Outcome?

____

Have you ever received psychological or psychiatric help before? ☐ Yes ☐ No

When?

____

FromWhom?

____

Purpose?

____

Results?

____

Have you ever been prescribed medication for a psychiatric or emotional problem?

☐ Yes ☐ No

When?

____

Prescribing Clinician?

____

Purpose?

____

Results?

____

____

Family history of:

☐ Depression ☐ Suicide Attempts ☐ Violence

☐ Eating Disorders ☐ Mental Illness ☐ Other:

☐ Sexual Abuse ☐ Emotional Abuse

☐ Alcoholism/ Drug Addiction ☐ Anxiety

Explain:

___

___

___

___

Please, indicate your major life stressors of the past 12 months?

- ☐ Serious Illness or Injury
- ☐ Death of a Close Friend or Family Member
- ☐ Major Illness in Family
- ☐ Gain of New Family Member
- ☐ Divorce/ Separation
- ☐ Job Change
- ☐ Other:

___

Please explain:

___

___

___

___

Social/ Relationship Information: Please indicate any of the following that you have experienced, you may write something about them on the back of this page, or attach pages, if you would like to. :

- ☐ Death of Child Your age at occurrence: ______
- ☐ Desertion by mother as a child Your age at occurrence: ______
- ☐ Desertion by father as a child Your age at occurrence: ______
- ☐ Divorce of Parents Your age at occurrence: ______
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Violence in the family
- ☐ Mental Illness of a family member
- ☐ Verbal Abuse
- ☐ Physical illness or hospitalization

Describe your present spouse or partner and how you currently get along with him/her.

___

___

___

___

___

Describe what you would like to be different in your life when you are done with therapy?

How do you relate to your children?

Employment Information:

What is the nature of your employment?

How long have you been employed in your current job?

How satisfied are you in this job?

☐ Not very satisfied ☐ Somewhat satisfied ☐ Comfortable ☐ Very satisfied

Are you satisfied that the income from your job adequately covers your living expenses?

☐ Not very satisfied ☐ Somewhat satisfied ☐ Comfortable ☐ Very satisfied

Do you have other sources of income? ☐ Yes ☐ No

Please, describe:

Spiritual Resources:

How significant a role does spirituality play in your life? How does this affect your daily life?

☐ None ☐ Somewhat important ☐ Significant ☐ Very significant

Explain:

Other:

This form answers the questions that your insurance company deems necessary for your records. However, I would like to know what you would like me to know about you as we begin our work together. You may add more pages if you want to.