Barbara Keyworth, LCSW
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Raleigh, NC 27607

Client Information

Name: ______________________ Date of Birth: ____________

Address: ______________________

City: ______________ State: ______ Zip Code: ____________

Cell #: __________ Work #: __________ Home #: __________

Employer and Occupation: ______________________

Relationship: ___ Married ___ Single ___ Living with partner ___ Separated ___ Divorced ___ Widowed

Name of spouse/partner (or parent/guardian of client under 21 years of age):
Name: ______________ Age: ______ Occupation: ______________

Children and stepchildren in your family:
Name: __________ Age: ______ Name: __________ Age: ______
Name: __________ Age: ______ Name: __________ Age: ______
Name: __________ Age: ______ Name: __________ Age: ______

Emergency Contact:
Name: ______________________ Phone: ____________
Relationship to you: ______________________

Employer of insurance holder: ______________________

Primary care physician/practice name: ______________________

Medical History

Allergies (adverse reactions to medications/food/etc)

____

____

Current Medications

Name:	Dose:	Purpose:	MD Prescribing:

Date of Last Physical Exam: ______________________

Psychiatric Hospitalizations? When?

____

Do you have any sleep problems? Use any sleep aids? __ Yes __ No (if yes, describe)

____

____

How many times per week do you generally exercise? _________________ What activity and how long?

____

Recent weight loss or weight gain? __ Yes __ No
Do you drink caffeine? Typical amount in a day? (sodas, energy drinks, coffee, iced or hot tea)

____

Do you use tobacco? (smoking or chewing) __ Yes __ No Daily amount: ______________________
Attempted to quit? __ Yes __ No

How many drinks (mixed, beer or wine) do you normally drink in a day/week?

____

Recreational drug use may affect your moods and health. Please talk with me about your patterns of use since this may affect starting a medication for depression or anxiety, etc.

Recent feelings of overwhelming sadness, grief, or depression? __ Yes __ No
Recent spells of crying or feelings of wanting to cry? __ Yes __ No

Past depression? __ Yes __ No
Did you seek treatment? Did it resolve without treatment? ______________________________________

Recent feelings of low self-esteem or worthlessness? __ Yes __ No

Increased irritability or anger? __ Yes __ No

Are you currently experiencing anxiety, panic attacks, or have any phobias? __ Yes __ No
Problems with anxiety, panic attacks or phobias is past? __ Yes __ No
Problems with obsessive compulsive behaviors like excessive cleaning, checking and re-checking, washing, excessive collecting, unable to stop thinking about something? __ Yes __ No

Do you have problems with chronic pain? __ Yes __ No

Financial Information

Insurance company: ____
Phone: ______________________________________ (see back of card for this- use mental health #)

Policy #: ____
Group #: ____

Name of Insured (if other than yourself): ____
Relationship to Insured: _________________________ Insured's date of birth: ___________________
Deductible: _________________________________ Deductible met? ___ Yes ___ No
Co-pay: __________________________ Coverage limit (if known): ____________________________
Annual sessions limit: ____

This is a strictly confidential patient medical record.
Re-disclosure or transfer is expressly prohibited by law.