Barbara Keyworth, LCSW
4601 Lake Boone Trail, Suite 2C
Raleigh, NC 27607

Client Information

Name: _____ Date of birth _____

Address: _____

City _____ State_____ Zip code _____

Cell phone _____ Work# _____ Home# _____

Email _____
(will be used for paperwork and your payments by credit card)

Employer and occupation _____

Relationship: __Married __Single __Living with partner __Separated __Divorced __Widowed

Name of Spouse/partner (or parents/guardians of client under 21 years of age)

	Name	Age	Occupation
Husband/wife or partner	_____	_____	_____
Children and stepchildren in your family	_____ (age)_____		_____ (age)_____
	_____ (age)_____		_____ (age)_____
	_____ (age)_____		_____ (age)_____

Employer of insurance holder _____

Emergency Contact Name: _____ Phone:_____

Relationship to you: _____

Primary Care Physician/practice name: _____

Medical History

Allergies (adverse reactions to medications/food/etc.)

_____

_____

Current Medications

Name	Prescribed dose	For (ex: depression, sleep, etc)	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? (include sodas/colas like Mountain Dew, Coke, Iced teas, energy drinks)_____

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: _____