CLIENT OUTPATIENT APPLICATION FORM

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

CONTACT INFORMATION

Name: ______________________________ Birthdate: ________________

Address: ____

Phone Number: ____

Email: ____

Best way to reach you: ____________________________

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous mental health treatment?
( ) no
( ) yes, with (previous therapist's name) _______________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: ____

Prescribed by: ____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? ____

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? ____

How often do you engage in recreational drug use?
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

What recreational drugs do you use?

____

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? ____________________

If yes, are you happy with your current position? ____________________

Please list any work-related stressors, if any: ______________________

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RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? ______________________

If you attend church regularly, please list church of attendance:

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OTHER INFORMATION

What are your goals for outpatient treatment? ___________________________

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The Outpatient Program is an 8-week program including 1 hr. of individual counseling with the Outpatient Director and 1 hr. of group meetings with peers. The weekly cost is $50/week for 8 weeks.

I___________________________________agree to pay $50/week for 8 weeks.
(signature)

Any unexcused absences may cause dismissal from the program.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.