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CENTER FOR WELLBEING
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Client's Legal Name
Last First Middle

Permanent Address
Street City State Zip

Home Phone Cell Phone Work Phone Email

Female ☐ Male ☐ Age Date of Birth / /

Single ☐ Divorced ☐ Occupation_______________

Married ☐ Widowed ☐ Social Security Number - -

Spouse's Name

Who is responsible for paying your bill? Relationship Occupation Soc Sec #

Permanent Address
Street City State Zip

Home Phone Cell Phone Work Phone Email

Employer Employer's Address Employer's Phone

Name of a Relative or Friend, Not Living With Client Relationship

Address Phone Numbers Email

Who is to be notified in case of emergency? Relationship

Address Phone Numbers Email

INSURANCE INFORMATION
Name of Insurance Company I.D. Number Group/Policy Number

Insurance Co. Address

Name of Insured Relationship Insured's Soc Sec #

CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I AUTHORIZE THE RELEASE OF ANY HEALTH INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I AUTHORIZE PAYMENT OF BENEFITS TO UNDERSIGNED PSYCHOLOGIST FOR SERVICES RENDERED.

SIGNED DATE SIGNED (INSURED OR AUTHORIZED PERSON)

Name Date

Age Marital Status Ethnicity Education Number of Children Ages

Name, Title, Phone Number of Your Health Care Providers

Referred By

Reasons for Making This Appointment

What You Want/Need

List the external supports for your wellbeing
(people, animals, plants, places, activities, things)

List the internal supports for your wellbeing
(your attitudes/beliefs, feelings, sensations, skills/capacities, qualities, characteristics)

Where do you turn for peace, comfort, solace?

List the Members of Your Household (include pets)

Name	Age	Relationship

Degree of comfort in your living situation

Means of relaxation

Current life stress

Means of stress relief

Fun/Recreation/Pleasure

Typical daily menu

Foods avoided

Foods most often eaten

Exercise routine

Sleep pattern

Sexual satisfaction

Religious/Spiritual practices

Substance Use	What	How Much	How Often
Alcohol			
Tranquilizers			
Sleeping Pills			
Marijuana			
Other Drugs			
Prescriptions			
Over the Counter Drugs			
Caffeine			
Nicotine			
Sweeteners			
Nutritional Supplements			
Other			

Health

Current emotional state

List all current and past medical or psychological symptoms or conditions

What brings on these symptoms or conditions?

What relieves these symptoms or conditions?

What other therapies or remedies have you tried?

How do these symptoms or conditions effect your participation in life?

Check the Life Experiences that apply to you

Accidents ☐ Injuries ☐ Illnesses ☐ Surgeries ☐
Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐
Assault/Violence ☐ Combat ☐ Natural/Human Disasters ☐
Alcohol/drug abuse/addiction ☐ Serious family medical or mental illness ☐
Loss of mate ☐ Addition/change to household ☐
Loss/change of home or school ☐ Birth/death of a significant other ☐
Sexual difficulty ☐ Relationship difficulty ☐
Work/school difficulty ☐ Learning/memory difficulty ☐
Arrest/legal difficulty ☐ Financial difficulty ☐

How do the checked items influence your daily life?

Other significant experiences affecting you?

Any thing else important for me to know?