Mary Pat Kelly, Ph.D.

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Present this form at your first appointment. Information you provide here is _protected as confidential._

Client Information

Date_________________

Name ____ Age _______ Birth date _____/_____/_____

Home Address_______________________________________ Email* ______________________________

OK to send a message? ☐ YES ☐ NO

____ Phone (_____) ____________________

City State Zip

OK to leave a message? ☐ YES ☐ NO

Occupation____ Work Phone (_____) ___________________

OK to leave message? ☐ YES ☐ NO

Relationship Status____________________ Age & Gender of Children ________________________________

How did you hear about Dr. Kelly's practice? ____

May we send a note of thanks to those who referred you? ☐ YES; ☐ YES, _but don't mention my name;_.
☐ NO, I'd rather you did not.

Reason(s) for currently seeking therapy: ____

____

____

Major Life Events: Are there any major events or situations in your life that you feel contribute to your seeking therapy? (Consider family and personal events – past or present)

____

____

Have you ever had therapy/counseling before? ☐ YES ☐ NO If so, when and with whom?

____

____

Please briefly described anything that was helpful or not helpful in your previous therapy experiences.
(This information is very helpful in assuring that you get the kind of services that are best for you.)

____

____

(Continued on other side – Please complete)

*Your email will receive an invitation join Dr. Kelly's network. The client portal allows for messaging, reminders etc. at a level of security appropriate for communicating confidential medical and personal information.

Medical Information:

Are you presently under a doctor's care for a health problem? ☐ YES ☐ NO

______________________________ Physician's Name ______________________________ Contact Information

If YES, please list your condition(s) and general care for this concern:

______________________:____

____

Is this condition ongoing? ☐ YES ☐ NO Does this problem effect your emotional well-being? ☐ YES ☐ NO

If YES, please describe: ____

____

Are you currently taking prescription medication? ☐ YES ☐ NO If YES, please **list name and dosage**.

______________ Prescription ______ Dosage ______________ Prescription ______ Dosage

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Family Mental Health History: Is there any personal or family history of any of the following? If yes, please indicate the family member's relationship to you in the space provided (self, father, grandmother, uncle, etc.) .

		Family Member			Family Member
Alcohol/Substance Abuse	☐ YES ☐ NO	________	Anxiety	☐ YES ☐ NO	________
Depression	☐ YES ☐ NO	________	Obsessive Compulsive Behavior	☐ YES ☐ NO	________
Bipolar/Manic-Depressive Illness	☐ YES ☐ NO	________	Eating Disorders	☐ YES ☐ NO	________
Suicide Attempts	☐ YES ☐ NO	________	Schizophrenia	☐ YES ☐ NO	________
Abuse/Domestic Violence	☐ YES ☐ NO	________	Other ________	☐ YES ☐ NO	________

Is there any other information not covered in this form you feel is important for Dr. Kelly to know? (Describe)

______________________:____

____

Note: Dr. Kelly does bill insurance or contract with insurance panels. (See Treatment Agreement for more information). ***If you plan to submit your receipt statements to insurance for reimbursement, complete the following section*** or. if you have an insurance card listing this information a copy can be taken at the office for your file.

Insurance Co. ______________________ Policy # ____________ Group # ____________

Name of Insured ______________________ Plan # ____________ Contract Code # ____________

Insured's ID# ______________________ Insurance Co. Phone # ____________

Any other relevant identifying information or numbers on your card or policy.

____

I look forward to working with you toward meeting your goals through therapy.