Robin Kaye Stilwell, M.A., L.M.F.T.

www.robinkstilwell.com

Please provide the following information and answer the questions below.
Please note: Information you provide here is protected as confidential information.

Date: _____

Name: _____ _____
(Last) (First) (Middle Initial) (Pronouns)

If under 18, name of parent/guardian: _____
(Last) (First)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Non-Binary

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital S tatus: □ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

If student, school name: _____

Please list any children/age: _____

With whom do you live _____

Referred by (if any): _____

Have you previously received any type of mental health services (including psychiatrist) ?

□ No □ Yes, previous therapist/practitioner: _____

Primary Care Physician:_____Telephone_____
Are you currently taking any prescription medication? □ Yes □ No
If yes, please list dosage and dates:

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Good Very good Excellent

Please list any specific health problems you are currently experiencing:

_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe _____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Good Very good Excellent

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Have you ever been hospitalized for a psychological condition? If yes, where?_____

Date_____ Diagnosis_____

Have you ever considered taking your own life? _____If yes, when/ how_____

_____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once a week? □ No □ Yes

Type and quantity _____

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:_____

Occupation_____ Employer_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, please describe:_____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weakness? _____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

Any other pertinent information that might be helpful?

_____

_____

Medical Insurance Information

If using insurance, please present your insurance card or any authorization forms provided by your company

Insurance company: _____ Name of insured: _____
Policy #:_____ Telephone :_____
Insurance co. address:_____
Authorization # (if needed):_____

I understand that Robin Kaye Stilwell, M.A., LMFT, utilizes electronic billing, therefore, my signature below acts as a signature on file.

I authorize the release of any medical or other information necessary to process claims to my insurance company.

*Signed*_____ *Date* _____