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Application for Services

Date: _____

Name of person (s) applying for services _____

Name of parent or guardian (if applicable) _____

Relationship to Child (if applicable) _____

Address _____

Mailing Address if different from above: _____

City _____ ZIP _____ SSN _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Sex _____ Age _____ Birthdate _____

Occupation _____ Employer _____

RelationshipStatus __Single__ CoHabitating __Married__ Widowed __Divorced__ Separated

Number of years in current relationship? _____ How many times have you been married? _____

Name of Spouse/Partner _____ SSN _____

Occupation _____ Employer _____ Work Phone _____

Sex _____ Age _____ Birthdate _____

Children: (Names and ages) _____

Person to Contact in Emergency: _____ Ph# _____

Educational History

Person applying for services educational history: _____

School attending? _____ Year in School _____

IEP __Yes__ __No__ Learning Disabilities __Yes__ __No__ Behavior Problems __Yes__ __No__

Insured/Responsible Party Information

Insurance Provider _____

Insurance ID number _____

Name of Insured _____

Relationship _____ Employer: _____

Mailing Address (if different from above) _____

Ph# _____ Date of Birth _____

Right to request how I contact you.

It is my normal practice to communicate with you at your home address and daytime phone number you gave me when you scheduled your appointment, about health matters such as appointment reminders, etc. Sometimes I may leave messages on your voicemail. You have the right to request that I communicate with you a different way.

- May I contact you at home? (Circle one) Yes No
- May I contact you at work? Yes No
- May I contact you by cell phone Yes No
- If not, how may I contact you? _____

Billing and insurance policy

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that **I am responsible for the full amount of my bill for services provided.**
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Please sign here _____

Drug, alcohol & addictions

Do you consume alcohol (how often and how much) _____

Family member(s) who is/are alcoholic? _____

Do you or have you ever taken street drugs? (What drugs, amount) _____

Are you currently in alcohol and drug treatment? Have you attended or completed inpatient or outpatient treatment?

Dates _____ Facility or agency _____

Any other addictions? _____

Mental and physical health history

Have you ever been in counseling/psychotherapy before? (With whom and for how long) _____

Are you currently taking any medications (over-the-counter, herbal or prescription?) _____

Physician (s) prescribing _____

Current physical exam _____ Dr. Clinic or Hospital _____

Mental exam _____ Dr., Clinic, or Hospital _____

History of mental illness in your family _____

Court or legal involvement

Current involvement in court care, litigation, or any legal difficulties: _____

Court _____

Probation or Parole Officer _____ Ph# _____

Attorney _____ Ph# _____

Guardian Et Litem _____ PH# _____

CPS Worker/FRS/IFPS _____ PH# _____

Reason for seeking therapy at this time _____

What is happening in your life which resulted in this appointment: _____

What would you like to see accomplished in therapy? _____

Chief Complaint (Check all that apply to you):

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Feeling that things around you are not real |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Lose track of time |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> worthlessness | <input type="checkbox"/> Anger/frustration |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Easily agitated/annoyed |
| <input type="checkbox"/> Sleep disturbances (more/less) | <input type="checkbox"/> Defies rules |
| <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> blames others |
| <input type="checkbox"/> Thoughts of hurting someone | <input type="checkbox"/> argues |
| <input type="checkbox"/> Isolation/social withdrawal | <input type="checkbox"/> excessive use of drugs/or alcohol |
| <input type="checkbox"/> sadness/loss | <input type="checkbox"/> excessive use of prescription drugs |
| <input type="checkbox"/> stress | <input type="checkbox"/> blackouts |
| <input type="checkbox"/> anxiety/panic | <input type="checkbox"/> physical abuse issues |
| <input type="checkbox"/> heart pounding/racing | <input type="checkbox"/> sexual abuse issues |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> spousal abuse issues |
| <input type="checkbox"/> trembling/shaking | <input type="checkbox"/> fear of going crazy |
| <input type="checkbox"/> fear of dying | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Obsessions/compulsive behaviors |
| <input type="checkbox"/> thoughts racing | <input type="checkbox"/> Can't hold onto an idea |
| <input type="checkbox"/> easily agitate | <input type="checkbox"/> excessive behaviors (spending, gambling) |
| <input type="checkbox"/> delusions/hallucinations | <input type="checkbox"/> not thinking clearly |
| <input type="checkbox"/> sweating | <input type="checkbox"/> other problems/symptoms _____ |
| <input type="checkbox"/> chills/hot flashes | _____ |

Check any of the following problems that your experience:

- | | | |
|---|---|--|
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> sexual problems | <input type="checkbox"/> bladder control |
| <input type="checkbox"/> excessive drinking | <input type="checkbox"/> appetite disturbance | <input type="checkbox"/> difficulty relaxing |
| <input type="checkbox"/> anger management | <input type="checkbox"/> stomach problem | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> nervousness | <input type="checkbox"/> pain (where) _____ | |
| <input type="checkbox"/> obsessional thoughts | <input type="checkbox"/> low self-esteem | <input type="checkbox"/> compulsive behaviors |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> relationship problems | <input type="checkbox"/> marital/family problems |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> poor impulse control |
| <input type="checkbox"/> loneliness | <input type="checkbox"/> feeling of unreality | <input type="checkbox"/> confusion |
| <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> flashbacks | <input type="checkbox"/> difficulty trusting |
| <input type="checkbox"/> headaches | <input type="checkbox"/> depression | <input type="checkbox"/> bowel problems. |

Where did you hear about me? _____

Sign _____ Date _____