ELIZABETH DYER, MA, LCSW
26 Park St., Suite 2220
Montclair, NJ 07042
973/509-7768

CLIENT INFORMATION

Today's Date: _____

Name: _____Birthdate: _____Age:_____ Gender: M__ F__

Address: _____

Zip:_____ Email Address: _____

Telephone: (H)_____(C)_____(W) _____

Ok to Leave Voicemail? YES NO Any specific directions?: _____

Presently living with: _____

How did you hear about Elizabeth Dyer?: _____

May we contact this person to thank them for the referral? Yes _____ No _____ Not Applicable_____

Emergency Contact: _____

Phone:_____

Current Situation:

Briefly describe the issue that prompted you to seek counseling at this time:

_____

_____

_____

_____

Have there been times when this issue got better or disappeared? Yes _____No _____

If yes, when?

_____

What do you think helped?

_____

_____

Were there times when this issue was especially bad?

_____

_____

Are there other people who play a major role in causing problems or in helping you cope with problems?

Yes_____ No_____

Explain:_____

_____

List three goals you hope to reach through therapy.

_____

_____

_____

Is there anything else that you believe might be important for your therapist to know at this time?

_____

_____

_____

Counseling History:

Have you had previous counseling/therapy? Yes _____ No_____

If yes, when?_____ For how long? _____ For what condition: _____

With Whom? (Name/ City) _____

Have you ever been hospitalized for a psychiatric condition? Yes_____ No_____ If yes, please describe briefly:

_____

What are your current supports and resources?

_____

_____

_____

Marital/ Family Status (Check One):

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Dissatisfied Extremely Satisfied

Relationship Satisfaction: 1 2 3 4 5 6 7 8 9 10

Spouse's Name: _____ How long have you been married _____

Previous marriages? _____ When/ for how long?_____

Reason for divorce? _____

Children's Names:	Ages:	Quality of Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Background:

Father's Name: _____ Age_____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school:_____ Occupation _____

Any medical, psychiatric or substance abuse problems that you know of?

_____

_____

Quality of relationship currently?

_____

Quality of relationship during childhood?_____

Mother's Name: _____ Age_____ Living _____ Deceased _____

If deceased, how and when? _____

Grade completed in school:_____ Occupation _____

Any medical, psychiatric or substance abuse problems that you know of?

_____

_____

Quality of relationship currently? _____

Quality of relationship during childhood? _____

Parents were: Married (how long?) _____ Divorced (how old were you?) _____Not Married _____

Relationship with stepparents if applicable? _____

Sibling's Names:	Ages:	Quality of Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other noteworthy childhood relationships? Explain:

_____

_____

_____

Significant childhood events (divorce, deaths, abuse, sickness, traumas, moving etc.)

_____

_____

_____

Education:

Years of education completed: _____

Degrees received: _____

Specialized training or trade school: _____

Do you have any learning or developmental disabilities? Please specify:

_____

_____

Do you have any background/experiences in the military? ____ Describe briefly:

_____

_____

Occupation:

Primary place of work: _____ Position: _____

How long have you worked there? _____ Describe the nature of your work: _____

_____

Do you find this work satisfying? _____

Number of hours work per week: _____

Spiritual Background:

Do you regularly attend religious services? Yes ____ No _____ If so, where? _____

Do you have a spiritual belief different from organized religion?

_____

_____

Do you practice meditation: _____

Medical History:

Describe any physical problems that require medication or physical care:

_____

_____

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult your primary care physician? _____

Who is your primary care physician? (Name/Address) _____

Other physicians whose care you regularly receive: _____

_____

Are you currently taking any prescription medication? Yes_____ No_____

Medical History (continued):

Please list your medications here:

Name:	Dosage:	For what condition:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug/Alcohol History:

Do you consume any caffeine? YES NO Description/Frequency: _____

Do you consume alcohol? YES NO Description/Frequency: _____

Do you use recreational drugs? YES NO Description/Frequency: _____

Have you had any problem in the following areas related to your use of alcohol or drugs?

If so, please mark: Family _____ Friends/social: _____ Employment: _____ Financial: _____

Health: _____ Legal: _____ Other:_____

Describe your view of your substance use:

_____ Not a problem

_____ Becoming a problem

_____ A severe problem

Have you ever attended:

_____ 12 step meetings

_____ Treatment program

_____ Addiction therapy

Longest period of sobriety and when: _____

How did you stay clean/sober? _____

_____

HEALTH INSURANCE

Insurance Carrier:

_____

Insurance Carrier Address:

_____

_____

Insurance ID #: _____ _____

Insurance Group#:_____

Insurance Name (self? Spouse?)_____

Date of Birth of Insured:_____

Employer of Insured: _____

PLEASE CHECK ALL THAT APPLY and CIRCLE THE MAIN PROBLEM

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety			People in General			Nausea/Vomiting		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/ Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Racing Thoughts			History of Sexual Abuse			Pain in Joints		
Trusting Others			Abusive Relationship			Allergies		
Communicating With Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Thoughts of Suicide			Fidget Frequently		
Alcohol			Suicide Attempt			Speak without Thinking		
Caffeine			Hurting Self			Waiting Your Turn		
Blackouts			Sleeping Too Much			Completing Tasks		
Eating Problems			Sleeping Too Little			Paying Attention		

Weight Gain/ Loss			Getting to Sleep/ Waking Too Early			Easily Distracted by Noise		
Abrupt Mood Changes			Chills or Hot Flashes			Hyperactivity		

FAMILY HISTORY OF: (Check all that apply)

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

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PROFESSIONAL POLICIES

Please read, sign and return this document as it contains important information about the business policies and professional services. If you have any questions, feel free to discuss them.

Payment and Billing Procedures: You are expected to pay for services at the end of each session. If you are covered by health insurance, claims will be submitted electronically to your insurance carriers at the end of each month.

Cancellation Policy: Appointments cancelled with less than 48 hours notice will result in a charge reflective of your fee, unless you are cancelling due to illness or emergency. If requested, all efforts will be made to reschedule within the week, depending upon appointment availability.

Confidentiality: Information shared between a client and psychotherapist is confidential and protected by law. Information cannot be disclosed without permission in writing from you. The exceptions to this rule are as follows:

1.The therapist receives information suggesting that the client presents a danger to self or others.
2.The therapist receives information suggesting that child abuse may have been committed. State law requires notification to the Division of Family Services.
3.Information in the therapist's file is subpoenaed and a judge upholds the subpoena.
4.Information is requested by your insurance company to authorize reimbursement. In this case, only information that is allowed by law will be provided which is usually name, address, CPT code, date of service, fee and diagnosis.

Thank you for completing these forms. The second copy is provided for your records and I look forward to working with you.

By signing below, I acknowledge that I have read and understood the above policies, and agree to follow them. It will also serve as my consent to receive treatment.

Signature of Client Date

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