

**Kristi Dean Frye, Ph.D., LPC
5646 Milton Street, Suite 340
Dallas, Texas 75206**

Client Background Information

Please answer all of the information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Name: _____ Date of First Visit _____

Address: _____

Home Phone: _____ (May leave message: Yes No)
Work Phone: _____ (May leave message: Yes No)

Cell Phone: _____ (May leave message: Yes No)
Other Phone: _____ (May leave message: Yes No)

Date of Birth _____ / _____ / _____ Age _____ SS# _____

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No

If yes: Previous Mental Health Professional/Agency _____

Phone _____ Dates of Service _____ (beginning - ending)

Have you ever been hospitalized for mental health concerns? Yes No

If yes: When _____ Where _____

*** GUARANTOR INFORMATION ***

Guarantor Name: _____ D.O.B. _____

Guarantor Address: _____

Home Phone: _____ SSN: _____ Relation to Pt. _____

Guarantor Employer: _____ Work Phone: _____

Insurance Company Name/Phone Number: _____

Member ID/Policy Number: _____ Group Number: _____

Assignment of Benefits: I hereby authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits directly to **Kristi Frye, Ph.D.**, Licensed Professional Counselor, for the services provided.

Guarantor Signature _____ Date _____

GENERAL INFORMATION *

Clients's current household:

List by Household your current family

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Currently involved in a custody dispute: No Yes (If yes, explain)

*** CLIENT'S HEALTH ***

Primary Care Physician: _____
Name Phone

Physical Disability: Yes No (If yes, explain) _____

Chronic Illness: Yes No (If yes, explain) _____

Terminal Illness: Yes No (If yes, explain) _____

What medication are you currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** FAMILY HISTORY/EXPERIENCES ***

Current Family Stressors:

Chronic illness of family member___ Death of significant person___ Domestic Violence___
Family member absent (explain)_____
Family member's disability/major accident/illness___
Family member emotional problems (explain)_____
Family member suicide (explain)_____
Financial problems___ Moved a lot___ Frequent Arguing___ Divorce___
Other _____

History of emotional/behavioral problems: Yes No

(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No

(If yes, please explain) _____

History of family violence: Yes No

(If yes please explain) _____

History of criminal activity: Yes No

(If yes, please explain) _____

*** CURRENT CONCERNS ***

Please mark the following items that apply.

- Abuse (physical, emotional, sexual)
- Adjustment to life changes (moving, getting married or divorced, aging, etc.)
- Drug or alcohol use (both legal and illegal drugs)
- Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- Family or Stepfamily relationship problems
- Feeling angry or irritable
- Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- Feeling sadness or depression NOT related to grief
- Feeling sadness or depression related to grief
- Health concerns (physical complaints and/or medical problems)
- Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- Non-family relationship problems (co-workers, peers, etc.)
- Parent-Child relationship (discipline, adoption, single parent, etc.)
- Sexual concerns (excessive masturbation, inappropriate acting out)
- Sleep problem (nightmares, sleeping too much or too little, etc.)
- Suicidal Ideation (thoughts of death, wanting to die)
- Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- Other (explain)_____

Briefly describe the problem that has brought you to therapy _____

How were you referred? _____
