20 Tacoma Ave North
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Tacoma WA 98403
Peter Simón, LMHC

Tacoma Counseling, PLLC
heal grow transform

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New Client Registration: Welcome! Please share the information below to aid me in understanding you and your concerns. Complete the form as thoroughly as possible. All information will be held confidentially, as explained in my disclosure statement and office policies. Please print clearly.

Today's Date:_____

Name: _____ Age:_____ Sex:_____
Last First MI

Address: _____ Social Security #: _____

_____ Date of Birth: _____
city state zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Acceptable Forms of Communication & Leaving Messages: (check those that are acceptable to you):

Home Phone____ Cell Phone____ Work Phone____ Email____ Texting____

Emergency Contact: Name _____ Relationship _____ Phone_____

Insurance Information

Please Note: Clients are financially responsible for annual deductibles, co-insurance and/or co-pays not covered by insurance. A copy of insurance card required at time of first visit.

Insurance Company _____ Phone _____

Client relationship to policy holder: Self _____ Spouse _____ Child _____ Other _____

Policy ID number: _____ Group number: _____

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

Address if different than client: _____ Phone: _____
city state zip

Client's Employer: _____ Other/secondary health benefit plan? Yes____ No____

Client Authorization

I authorize payment by my insurance company to provider Tacoma Counseling, PLLC and Peter Simón, LMHC for services provided. I agree to permit Tacoma Counseling, PLLC and Peter Simón, LMHC to release to my insurance company and/or their representatives any information necessary for processing my insurance claims. I further authorize the release of any medical or other information necessary to process this claim. This information may include: personal information listed above, diagnosis, dates of office visits, types of service, and the amount of charge. I also request payment of government benefits either to myself or to the party who accepts assignment. My signature also indicates that the information I have provided is true and complete. I understand that failure to provide complete information will result in my being held personally responsible for all charges incurred. I understand that I am held financially responsible for unreimbursed charges not covered by the insurance policy.
Cash Paying Client: I understand that payment is due at the time services are rendered.

Client Signature: _____ Date: _____

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For the following sections of personal history below, please note: Answers can be brief. You can expand on them during your appointment. Anything you are uncomfortable writing down need not be included on this form but can be discussed in person.

Personal and Family History

Preferences:

Preferred to be called: _____ Preferred pronouns? _____

Relationship Status:

Never Married:	_____	Dates:
Married:	_____	How Long? _____
Living w/Partner:	_____	How Long? _____
Separated:	_____	How Long? _____
Widowed:	_____	How Long? _____
Divorced:	_____	How Long? _____

Sexual Identity & Orientation:

___ Non-Binary
___ Female
___ Male
___ Heterosexual
___ Lesbian
___ Gay
___ Bisexual
___ Transgender Person
___ Queer

List any previous marriage partners, or significant relationships, with dates: _____
_____

If married or in a committed partnership:
Spouse/Partner's Name: _____ Age: _____ Birth Date: _____ # Years Together: _____
Spouse/Partner's Current employer or school: _____ Occupation and/or field of study: _____
Education Level: _____ Nationality/Ethnic identity: _____
Previous marriage partners, or significant relationships, (please include dates): _____
_____

Children/Stepchildren:

Name	Age	Birth Date	Gender/Sex	Relationship to You?	Living With You?

Additional info./other comments _____
_____

Who do you live with? _____ Pets _____

Major life stressors in the past 12 months or so:

Death of a family member or close friend _____ Divorce/Separation _____
Job Issue _____ Serious personal illness or injury _____
Major illness or injury in family _____ Gain of new family member _____
Move _____ Financial _____ Other changes in the family _____
Other stressor _____

Please indicate any of the following you have experienced:

Have you experienced? Sexual abuse _____ Emotional abuse _____ Physical abuse _____ Neglect _____
Violence in the family _____ Mental illness of a family member _____ Other trauma _____
_____

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Please indicate any of the following you have experienced (continued)**:**

Death of Mother _____ Your age at occurrence _____
Death of Father _____ Your age at occurrence _____
Death of Child _____ Your age at occurrence _____ Child's age _____
Death of Sibling _____ Your age at occurrence _____ Siblings age _____
Desertion by Mother _____ Your age at occurrence _____
Desertion by Father _____ Your age at occurrence _____
Divorce of Parents _____ Your age at occurrence _____
Separation of Parents _____ Your age at occurrence _____

Treatment Information:

Have you ever received mental health/behavioral health counseling in the past? Yes____ No____
If so, when? _____ From Whom? _____
Purpose of previous counseling? _____
Your opinion – did you find the counseling helpful/useful? _____
Have you ever been diagnosed with a mental health issue? Yes_____ No_____
If so, do know/remember what the diagnosis was? _____
Have you ever been prescribed mental health medication? Yes ___ No ___ When? _____

Name of mental health medication(s) no longer taking? _____
Results of the medication? _____
Currently taking mental health medication (such as an antidepressant, anti-anxiety medication)? Yes____No____
Name and dosage of the medication _____
Have you ever been hospitalized for a psychiatric or emotional health reason? Yes ___ No ___ When? _____
Have you ever been in a drug or alcohol treatment program? Yes ___ No ___ When? _____ Inpatient____ Outpatient____
Where? _____ Outcome? _____

Medical Information
Primary Care Physician or Clinic _____ Phone _____
Date of latest physical exam _____ Major surgeries _____
Chronic Illnesses _____ Injuries _____
Other pertinent medical _____
Medications – *not mental health medications* (Name, dosage, frequency) _____
_____

How would you describe your overall physical health and well-being at this time?
Poor ____ Fair ____ Average ____ Good ____ Excellent ____

Substance Use
Do you currently use tobacco products? yes___ no___ Use in the past?: yes____ no____
What type? cigarettes_____ chewing tobacco _____ pipes_____cigars_____other _____
If current, how much? _____
Frequency: Less than once a month____ once a month____ once a week____ once a day_____ Several times a day_____
Do you use marijuana products? yes____ no_____ Use in the past?: yes____ no____
If current, how much? _____
Frequency: Less than once a month____ once a month____ once a week____ once a day_____ Several times a day_____
Do you consume alcohol? yes____ no____ Use in the past?: yes____ no____
What type? Beer____ Wine____ Hard Liquor_____ Other info on alcohol _____
If current, how much? _____
Frequency: Less than once a month____ once a month____ once a week____ once a day_____ Several times a day_____
binge drinking? _____ black-outs? _____
Do you use any street drugs, misuse prescription drugs or use anything else to get high? Yes____ No____ Name of drug(s) and frequency _____
_____

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Do you experience any the following behaviors as compulsive and/or addictive behaviors? Mark yes_or_ no___
gambling _____ sex_____shopping_____ gaming_____internet_____other _____

Employment/Education background

Your current employment status:
Full time____ Part time____ Hours per week_____ Unemployed_____ Stay at home by choice_____ Disabled_____
Type of Disability _____
Current position / Job title _____ Employer _____
How long at current job? _____ How long unemployed or disabled? _____
How many jobs have you had in the last 5 years? _____
How satisfied are you with your current job? Not satisfied____Somewhat satisfied___ Comfortable___Very satisfied___
Career goals _____
Education: Did not finish high school____ High School Diploma____ GED____ Some college____

College Degree _____

Spiritual Resources

How important is spirituality in your life? Not important___ Somewhat important___ Significant___ Very significant___
Optional: Religious affiliation / faith / beliefs / denomination _____

How would you describe your overall emotional & mental health and well-being at this time?
Poor ____ Fair ____ Average ____ Good ____ Excellent ____

Which of the following describe or relate to the concerns which bring you to therapy?

Alcohol Problems	_____	Anxiety	_____	Abuse Survivor:	_____
Drug Problems	_____	Relationship with:		Sexual	_____
Anger	_____	Partner	_____	Emotional	_____
Depression	_____	Parents	_____	Physical	_____
Loneliness	_____	Children	_____	Abuse Perpetrator:	
Guilt	_____	Coworkers	_____	Sexual	_____
Sexual Concerns	_____	Others	_____	Emotional	_____
Fear	_____	Elevated Mood	_____	Physical	_____
Grief	_____	Hopelessness	_____	Eating/Food Issues	_____
Midlife Issues	_____	Sleep Problems	_____	Self-Doubt	_____
Suicidal Feelings	_____	Strange Thoughts	_____	Legal Issues	_____
Spiritual Issues	_____	Finances	_____	Work Issues	_____
Physical Health	_____	Self-Esteem	_____	Loss of Interest	_____

Please describe the main concern(s) that have prompted you to seek counseling: _____

What changes would you like to make in your life? _____

What are your goals for counseling, what would you like to achieve? _____

Is there anything else that's important to know? _____