Peter Simón, LMHC
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phone: 253 232-8722

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www.tacomacounseling.net

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 #: _____________________
**ONLY if requested**

__________________________________________________________ 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 or Benefits 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.

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Client Signature: ______________________________ Date: ______________________________

*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

Preferred to be called: ________________________________ Preferred pronouns? ________________________________

**Relationship Status:**

| | | Dates: |
|---|---|---|
| Never Married: | ________ | |
| 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
___ LGBTQ ~ Please elaborate:
________________________________
________________________________

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 ______

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Violence in the family _______________ Mental
illness of a family member ______________
Other trauma ___ ______________________
________________________________________________________________________________
________________________________________________________________________________

**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____

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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 ____________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

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**: ________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

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**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?** ______________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________