**** Jill Ellingson, MA, LMFT

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**Client Information**

Date \_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M/F \_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip ­­\_\_\_\_\_\_\_\_

Phone \_\_\_ Home \_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? Y\_\_\_ N\_\_\_ OK to text? Y\_\_\_ N\_\_\_

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of communication: phone \_\_\_\_\_ email\_\_\_\_\_ text message \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Relationship to Policyholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Client is a Minor, Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group ID#\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Relationship to Policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Reasons for seeking help at this time:

**\*\*\*PLEASE ENTER N/A FOR ANY ITEMS THAT ARE NOT APPLICABLE\*\*\***

1. Previous or current counseling:

|  |  |  |
| --- | --- | --- |
| Name of Counselor or Agency | Year | Approximate Number of Sessions |
|  |  |  |
|  |  |  |
|  |  |  |

1. Current employment situation and do you like it?
2. Marriages/relationships and how is it going currently:
3. Names and ages of children and any information about them that would be helpful:
4. Are you currently under medical care? Y\_\_\_ N\_\_\_ If yes, please explain/describe:
5. What medications have you used in the past 6 months? (include any herbal medications or supplements). Please list frequency and dosage information.
6. Any concerns with substance abuse (including alcohol)? Y\_\_\_\_ N \_\_\_\_ If yes, please explain:
7. How significant of a role does religion / spirituality play in your life?

None\_\_\_\_\_ Somewhat significant \_\_\_\_\_ Significant \_\_\_\_\_\_ Very Significant \_\_\_\_\_\_

1. Family history of mental health issues:

11. Please underline any of the following struggles that pertain to you:

Anxiety Inability to cry Fears/Phobias Eating disorders

Panic attacks Crying spells Guilt Difficulty concentrating

Sexual problems Depression Anger Irritability / Impatience

Headaches Suicidal thoughts Separation/Divorce Relationships

Financial problems Drug/Alcohol use Career choices Thought patterns

Self-Control Unhappiness Religious matters Rage

Work stress Health problems Cutting/Self-mutilation Hitting people or things

Chronic pain Legal problems Poor self-image Insomnia/troubled sleep

Memory Grief Loneliness Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Is there anything else I should know about prior to our beginning your treatment?

I am required by law to obtain your signature as an indication that you have been given and have received a copy of the Client Bill of Rights and a copy of the Notice of Privacy Practices prior to the provision of service.

**I have received a copy of the Client Bill of Rights**

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have received the Notice of Privacy Practices**

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_