IRVING & ASSOCIATES IN BEHAVIORAL HEALTH, P.C.

5151 Mochel Drive, Suite 307
Downers Grove, IL 60515

Date: ______/______/______

Client Name: ________________________________ SSN: _______/______/_______

Date of Birth: ________________ Age: ___________ Sex: Male_____ Female_____

Address: ____

City/State/Zip: ____

Home Phone Number__________________ Is it okay to leave a message here? Y/N

Work Number______________________ Is it okay to leave a message here? Y/N

Cell Number________________________ Is it okay to leave a message here? Y/N

Email: _____________________________ Is this an acceptable form of communication? Y/N

Student: YES____NO____ IF YES: FULL TIME_____ PART TIME_____

Highest level of education____

Employer____

Occupation____

Who referred you? How did you learn about our services? _____________________

Have you ever consulted a Psychotherapist or mental health professional before? YES / NO

If so, when, with whom, and for how long?

____

What are the reasons you are seeking therapy now?

____

____

What do you hope to gain/accomplish from therapy?

____

____

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Emergency Information

In case of an emergency, notify: ___________________________________

Relationship: ______________________ Phone: ______________________

Family Physician__________________________________ Physician Phone: ___________________

Relationship Status

____Single ____Married/committed relationship

____Widowed ____Divorced/separated

How long have you been married/in a committed relationship? ___________________________

Spouse/Partner's Name: __________________ Spouse/Partner's Employer: ____________________

Spouse/Partner's Cell Phone: _________________ Spouse/Partner's Work Phone: _______________

If Client is a Minor (under the age 18)

Parent/Guardian Name: ______________________ Cell Phone: _____________________

Employer: __________________________________ Work Phone: ___________________

Name of Individual Responsible for Billing: ____

Address (if different from above): ____

Home Phone: Work Phone: ____

Medical History: List all prescriptions, OTC, and herbs.

Medication	Dosage	Start Date	D/C Date		
				Last History and Physical	Date
				Chronic Medical Conditions	Onset
				Surgical Procedures	Date