***Meredith O'Brien & Affiliates, LLC***
License#: 44SC05384300, NPI#1841558756
65 Mechanic Street, L2, Red Bank, New Jersey, 07701
732-977-9729 Tax ID #45-4926269

## Client Profile:

**Referred by _____**

Last Name_____ First Name_____

Street Address_____ City/State/Zip_____

Email Address_____ Receive our Newsletter? Yes No

DOB_____ Age_____ Grade/School/Employer_____

Home Phone _____Cell Phone _____Can leave message?_____

Emergency Contact_____Relationship_____Phone_____

**Responsible Party for Payment: Check_____ if the information above is the same.**

Last Name_____ First Name_____

Street Address_____ City/State/Zip_____

Home Phone _____Cell Phone _____Can leave message?_____

## Family History

| | Name | Sex | Age | Yes/No (live with you?) |
|---|---|---|---|---|
| Client | | | | |
| Mother | | | | |
| Father | | | | |
| Spouse | | | | |
| Children/Siblings | | | | |
| | | | | |
| | | | | |
| Others in household | | | | |
| Other significant members | | | | |

## Background information

Please state why you are here today

_____
_____
_____
_____

What would you like to see changed after treatment is completed?

_____
_____
_____

What prior treatment/counseling history have you had?

| Type | Dates | Who/Where? | Was it helpful? |
|---|---|---|---|
| _____ | _____ | _____ | Yes/No |
| _____ | _____ | _____ | Yes/No |
| _____ | _____ | _____ | Yes/No |

## Health Background

Current Provider of Medical Care/Psychiatrist

| Physician | Address | Telephone # |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List all current medications and doses

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List all past Diagnoses

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| **Have the following changed in the last 6 months?** | | Yes (explain) |
|---|---|---|
| Sleeping habits | No | _____ |
| Energy level | No | _____ |
| Amount of water you drink daily | No | _____ |
| Urination/ Bowel movement frequency | No | _____ |
| **Do you?** | | Yes, how often? |
| Smoke | No | _____ |
| Drink alcoholic beverages | No | _____ |
| Drink coffee/tea | No | _____ |

Please list all past and current medical symptoms/illnesses/pain/treatment

_____
_____
_____

| **Stressors** | **Yes** | **No** |
|---|---|---|
| Unemployment | _____ | _____ |
| Recent decrease in income | _____ | _____ |
| Illness in family member | _____ | _____ |
| Death in family | _____ | _____ |
| Any other significant losses | _____ | _____ |
| Drug/alcohol abuse in family | _____ | _____ |
| Exposure to violence | _____ | _____ |

**Payment is requested at time of service. If you need to cancel an appointment 24 hour notice is required to avoid being charged for the session, which is not billable for insurance reimbursement.**

**Client Signature_____ Date _____**

**Therapist Signature_____Date_____**