

Sherri H. Rawsthorn, LCSW

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Phone/Fax: (678)377-6992

Client Name:			
Street Address:			
City:		State:	Zip:
Birth Date:	Age:	Gender: __ Male __ Female	
Home Phone:		Work Phone:	
Cell Phone:		Other Phone:	
Employer/School:			

Parent/Guardian Name (for clients under age 18):			
Street Address:			
City:		State:	Zip:
Birth Date:	Social Security #:		
Home Phone:		Work Phone:	
Cell Phone:		Other Phone:	
Employer:			
Insurance Provider and Member #:			

Why are you are seeking treatment:

Check all symptoms/problems you have experienced during the past 60 days:

- | | | |
|--|---|---|
| <input type="checkbox"/> Sleep changes | <input type="checkbox"/> Work problems | <input type="checkbox"/> Paranoid thoughts |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> School problems | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Obsessive thoughts |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Poor concentration/attention | <input type="checkbox"/> Compulsive behavior |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Runaway risk | <input type="checkbox"/> Tics/Tourette's |
| <input type="checkbox"/> Violence | <input type="checkbox"/> Family issues | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Couple issues | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Dissociative behavior | <input type="checkbox"/> Sexual orientation concern |
| <input type="checkbox"/> Suicidal thoughts/behaviors | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Spiritual/religions concerns |
| <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Self-mutilation/cutting | <input type="checkbox"/> Other: _____ |

List current medical conditions/illnesses:

List current medications (include dosage and frequency):

Name of current medical provider(s):

Primary Care Physician: _____

Phone Number: _____

Additional Provider: _____

Phone Number: _____

Have you ever had a head injury or seizure? Yes No

If Yes, Describe:

Please check all substance you have used in the past 30 days:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Heroin |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Cocaine/Crack |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Pain killers | <input type="checkbox"/> Amphetamines/Speed |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> LSD/PCP/Ecstasy | <input type="checkbox"/> Inhalants |
| <input type="checkbox"/> Other: _____ | | |

Have you ever been treated for drug/alcohol problems? Yes No

If Yes, When? _____

Where? _____

Have you ever engaged in any other addictive behavior (e.g. Food, gambling, sex, shopping, etc.)?

If Yes, Describe:

Describe any current or relevant legal problems and concerns:

What is your occupation?

Describe any concerns related to your employment?

What is your current or highest level of education? _____ Grade Some college/technical school

College/technical degree Graduate degree Post graduate degree Other: _____

Describe any educational or school concerns:

Are there any developmental problems or concerns? Yes No

If Yes, Describe:

Have you ever had any concerns regarding childbirth complications? Yes No

List name(s) and relationship of anyone in your family who has a history of psychological, developmental, emotional, behavioral, or drug/alcohol problems?

How would you describe your support network? Good Fair Poor

***I authorize the release any medical or other information necessary to process my insurance claims. I also authorize payment of insurance benefits to be paid directly to Sherri H. Rawsthorn, LCSW, P.C. for services rendered.*

***I agree to pay all fees and amounts for any and all psychotherapeutic services provided by Sherri H. Rawsthorn, LCSW, P.C. not paid by my insurance. I understand I will be responsible for paying a \$50.00 fee if I cancel an appointment with less than 24 hours advance notice.*

Client Signature

Date

Parent or Guardian's Signature (if client is under age 18)

Date