

**KEN VOORHEES, CSW**

DATE \_\_\_\_\_ REFERRED BY \_\_\_\_\_

**PERSONAL INFORMATION**

NAME \_\_\_\_\_  MALE  FEMALE  TRANSGENDER  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

**EDUCATION**

ELEMENTARY SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_  
HIGH SCHOOL \_\_\_\_\_ CURRENT YEAR OR GRADUATION YEAR \_\_\_\_\_  
COLLEGE/TECHNICAL \_\_\_\_\_ CURRENT YEAR OR GRADUATION YEAR \_\_\_\_\_  
OTHER TRAINING OR MILITARY EXPERIENCE \_\_\_\_\_

**EMPLOYMENT**

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
Where do you prefer to receive calls?  HOME  WORK  
When is the best time to reach you? TIME \_\_\_\_\_ DAYS \_\_\_\_\_  
May we leave messages on your answering machine?  YES  NO

**IF A CHILD, CLIENT LIVES WITH**

BOTH PARENTS  MOTHER  FATHER  CUSTODIAL PARENT  OTHER/WHO?

**MARITAL STATUS**

SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED  
 DOMESTIC PARTNER

**SPOUSE OR DOMESTIC PARTNER'S NAME**

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

**FAMILY**

<b>FATHER'S NAME</b> _____	<b>MOTHER'S NAME</b> _____
ADDRESS _____	ADDRESS _____
CITY, STATE, ZIP _____	CITY, STATE, ZIP _____
PHONE _____	PHONE _____
OCCUPATION _____	OCCUPATION _____
EMPLOYER _____	EMPLOYER _____
EMPLOYER ADDRESS _____	EMPLOYER ADDRESS _____
EMPLOYER PHONE _____	EMPLOYER PHONE _____
IF DECEASED, CAUSE OF DEATH _____	IF DECEASED, CAUSE OF DEATH _____

**BROTHERS**

\_\_\_\_\_  
AGE \_\_\_\_\_  
\_\_\_\_\_  
AGE \_\_\_\_\_  
\_\_\_\_\_  
AGE \_\_\_\_\_  
\_\_\_\_\_  
AGE \_\_\_\_\_

**SISTERS**

\_\_\_\_\_  
AGE \_\_\_\_\_  
\_\_\_\_\_  
AGE \_\_\_\_\_  
\_\_\_\_\_  
AGE \_\_\_\_\_  
\_\_\_\_\_  
AGE \_\_\_\_\_

**CHILDREN**

NAME _____	SEX _____	AGE _____
NAME _____	SEX _____	AGE _____
NAME _____	SEX _____	AGE _____
NAME _____	SEX _____	AGE _____

**IN CASE OF AN EMERGENCY, WHO MAY WE CONTACT ON YOUR BEHALF?**

NAME \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ ADDRESS \_\_\_\_\_

**COURT/LEGAL ISSUES**

**PRIMARY PHYSICIAN**

NAME OF DOCTOR \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I authorize the release of confidential information regarding my treatment or my child's treatment by Ken Voorhees, CSW to my primary physician for the purpose of coordinating care. YES \_\_\_\_\_ NO \_\_\_\_\_

**INSURANCE**

**PRIMARY INSURANCE**

**ADDITIONAL INSURANCE**

NAME OF INSURED \_\_\_\_\_  
RELATIONSHIP TO CLIENT \_\_\_\_\_  
INSURED'S DATE OF BIRTH \_\_\_\_\_  
SOC. SEC. # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
GROUP # \_\_\_\_\_  
EMPLOYEE/CERT # \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_  
RELATIONSHIP TO CLIENT \_\_\_\_\_  
INSURED'S DATE OF BIRTH \_\_\_\_\_  
SOC. SEC. # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
GROUP # \_\_\_\_\_  
EMPLOYEE/CERT # \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION INCLUDING PROFESSIONAL OPINIONS, TREATMENT SUMMARIES, DIAGNOSIS AND PROGNOSIS RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH CARE PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO KEN VOORHEES, CSW ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS.

X \_\_\_\_\_  
SIGNATURE OF CLIENT // OR PARENT OF MINOR CLIENT DATE

**Ken Voorhees, CSW**

**Medical Information**

Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ Date \_\_\_\_\_

What is the reason you are seeking help at this time? \_\_\_\_\_

\_\_\_\_\_

**Please check the items below which apply to you in the past six months:**

- |  |   |
|--|---|
| <input type="checkbox"/> change in appetite                | <input type="checkbox"/> worried about your appearance    |
| <input type="checkbox"/> loss of weight                    | <input type="checkbox"/> forgetfulness or memory problems |
| <input type="checkbox"/> weight gain                       | <input type="checkbox"/> anger                            |
| <input type="checkbox"/> binge or purge                    | <input type="checkbox"/> verbal fighting                  |
| <input type="checkbox"/> worried about your weight         | <input type="checkbox"/> physical fighting                |
| <input type="checkbox"/> trouble sleeping                  | <input type="checkbox"/> sexual problems                  |
| <input type="checkbox"/> high energy                       | <input type="checkbox"/> difficulty concentrating         |
| <input type="checkbox"/> low energy                        | <input type="checkbox"/> racing thoughts                  |
| <input type="checkbox"/> restless/difficulty sitting still | <input type="checkbox"/> sad or depressed                 |
| <input type="checkbox"/> anxious or nervous                | <input type="checkbox"/> crying spells                    |
| <input type="checkbox"/> loss of interests                 | <input type="checkbox"/> thoughts of suicide              |
| <input type="checkbox"/> feel like mind playing tricks     | <input type="checkbox"/> self hurt/harm                   |

Have you ever had counseling/therapy or medication for any of the above? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "Yes," where, when, and from whom? \_\_\_\_\_

Have you ever been hospitalized for any of the above? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If "Yes," where, when, and from whom? \_\_\_\_\_

When did you last have a complete physical exam? \_\_\_\_\_  
Who is your primary physician? \_\_\_\_\_

How do you rate your overall health? \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor  
What is your main concern about your health? \_\_\_\_\_

Any other medical problems? If "Yes," please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please complete the following regarding your current medication:**

Name of Medication/Herbs	Prescription Yes/No	When Prescribed	Amount Daily	Reason

{Over}

Do you have any **Allergies**? If "Yes," please describe \_\_\_\_\_

Do you use Tobacco? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you use Caffeine? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you currently use any Illicit Drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever abused Prescription or Illicit Drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you drink Alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No

How many times per week? \_\_\_\_\_

On an average, how many drinks per time? \_\_\_\_\_

**Have you ever:**

Thought you should cut down on your drinking or drug use? \_\_\_\_\_ Yes \_\_\_\_\_ No

Been annoyed when others have asked you about your drinking or drug use? \_\_\_\_\_ Yes \_\_\_\_\_ No

Felt guilty about how much you drink or use? \_\_\_\_\_ Yes \_\_\_\_\_ No

Had a drink/used to get going or to treat a hangover? \_\_\_\_\_ Yes \_\_\_\_\_ No

Had anyone complain about your drinking/using? \_\_\_\_\_ Yes \_\_\_\_\_ No

Gotten in trouble with the law, family members, or friends when you drink/use \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you usually get into trouble when you drink/use? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you gamble? \_\_\_\_\_ Yes \_\_\_\_\_ No

How many times per month? \_\_\_\_\_

What percent of your monthly income do you spend per month on gambling? \_\_\_\_\_

**Please check the items below which describe medical symptoms you have had in the past 12 months?**

\_\_\_\_\_ persistent cough

\_\_\_\_\_ shortness of breath

\_\_\_\_\_ heart disease

\_\_\_\_\_ high blood pressure

\_\_\_\_\_ abnormal heartbeat

\_\_\_\_\_ balance problems/falling

\_\_\_\_\_ severe/persistent headaches

\_\_\_\_\_ loss of consciousness

\_\_\_\_\_ seizures

\_\_\_\_\_ numbness or weakness of limbs/body

\_\_\_\_\_ muscle weakness

\_\_\_\_\_ muscle pain

\_\_\_\_\_ joint aches/pains

\_\_\_\_\_ bruise easily

\_\_\_\_\_ kidney infection/disease

\_\_\_\_\_ trouble urinating

\_\_\_\_\_ urinary infection

\_\_\_\_\_ liver disease

\_\_\_\_\_ stomach/abdominal pain

\_\_\_\_\_ vomiting

\_\_\_\_\_ change in vision/trouble with eyes

\_\_\_\_\_ change in hearing/trouble with ears

\_\_\_\_\_ change in sense of smell

\_\_\_\_\_ feeling clumsy or dropping things

\_\_\_\_\_ pain in mouth or trouble swallowing

\_\_\_\_\_ sore/swollen neck/glands

\_\_\_\_\_ speech problem

\_\_\_\_\_ voice problems

\_\_\_\_\_ thyroid disease

\_\_\_\_\_ pain/lumps/drainage from breasts

**Client's Signature** \_\_\_\_\_

**Signature of Parent** if completed on behalf of a minor child \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_

Referred for a Physical Exam? \_\_\_\_\_ Yes \_\_\_\_\_ No

To Whom \_\_\_\_\_ Client willing to accept referral \_\_\_\_\_ Yes \_\_\_\_\_ No

Referred for a Psychiatric Evaluation? \_\_\_\_\_ Yes \_\_\_\_\_ No

To Whom \_\_\_\_\_ Client willing to accept referral \_\_\_\_\_ Yes \_\_\_\_\_ No