Gabe Yandell PLLC
3839 South Boulevard, Suite 200
Edmond, OK 73013
(405) 694-1005

Date: _____

BACKGROUND INFORMATION

Last Name: _____ First Name: _____ MI: ____

SSN: _____-____-_____ DOB: ___/___/___ Age: ____ Sex: ☐ M ☐ F Ethnicity _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: ____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail_____

Check if we can leave a message on your: ☐ Home phone ☐ Work Phone ☐ Cell Phone

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _____ First Name: _____ MI: ___

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Other Phone: _____ Relationship: _____

HEALTH CARE RESOURCES

☐ Private Insurance ☐ Public Insurance (Medicaid) ☐ None

Provider: _____ Policy ID Number: _____Policy Group Number_____

Policy Holder (cite name as is appears on the insurance card): _____

Policy Holder Employment:_____

Policy Holder Date of Birth _____ Additional Info_____

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one): ☐ Alone ☐ w/Significant Other ☐ in Community Based Shelter
☐ Other: _____ Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female
Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female
Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female

OTHERS LIVING IN HOME (use back if needed)

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female

City & State _____ If minor, with whom _____

Last Name: _____, First _____, MI ___ Age __ ☐ Male ☐ Female

City & State _____ If minor, with whom _____

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? _____

Please write a couple of sentences concerning the reason for your request of services.

_____

_____

_____

Please check your employment status □ Full-time □Part-Time □Unemployed □Not in Labor Force

If employed, who is your employer?

_____

What is the highest level of education you have received?_____

In the past 60 days, how many days have you or the minor been absent from school and/or daycare? ____

Have you served in the military? ____ If so what is your current status? _____

Are you currently receiving any government assistance? ____ If so, what programs? _____

Please check all that apply □ Medicaid □ Medicare □ SSI □ SSDI

Are you currently using tobacco products? ___ If so, please describe your use. _____

How many days have you used tobacco in the past 30 days?_____

Are you currently using alcohol? ___ If so, please describe your use. _____

Are you currently using other substances? ___ If so, please describe your use. _____

How many times have you been in jail in the past 30 days?_____ 12 months?_____

Have you ever experienced (check all that apply): □ Physical Abuse, □ Emotional / Verbal Abuse, □ Sexual Abuse / Molestation / Sexual Misconduct, □ Neglect, □ I would rather not answer these

Have you ever attempted suicide?
YES or NO

If "yes," identify month & year of attempt(s) _____

Have you ever had thoughts of suicide?
YES or NO

If "yes," identify month & year of latest thought(s) _____

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐ No

If yes, describe: _____

_____

Physician Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Are you currently taking medications? ☐ Yes ☐ No

If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
☐	_____	_____	_____	_____
☐	_____	_____	_____	_____
☐	_____	_____	_____	_____

Please list any allergies:_____

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No
If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many self-help meetings have you attended in the past 30 days?_____

Please include any other information you feel is important for therapist to know.

Client Name_____ CONFIDENTIAL