Christy Lincoln, LCPC
Psychotherapy and Consultation
Get Back To Being You, P.C.

General Information

Name _____
Address_____
Home Phone_____Cell Phone_____
Preferred number for contact_____Ok to leave a message?_____
Date of Birth_____Your age today_____Sex_____
Were you referred to me? _____
If yes, who referred you?_____
If no, how did you hear about me?_____
Occupation_____
Education Level_____

Family

Marital Status_____
Spouse/Partner_____His/her occupation_____
Children (name, age, sex)_____
_____
Is your father living? _____Where?_____Date of Death?_____

His occupation_____
What is/was your relationship with your father like? _____
_____

Is your mother living? _____Where?_____Date of Death?_____

Her occupation_____
What is/was your relationship with your mother like? _____
_____
Siblings/Other Important People
_____
_____

Recent changes in your life or those close to you (marriages, deaths, job changes, divorces, moves, serious illness)_____

_____

Medical

Family Physician_____Address_____

Significant illnesses, injuries, physical conditions, hospitalizations, etc (give dates)_____
_____

Medications/Drugs now used_____
_____
Previous counselors_____

Interests

_____
_____

Problems/Concerns

Please mark any specific problems or concerns and use the spaces provided to specify if necessary.

__Abuse Survivor Issues
__Abandonment and/or Fear of
__Adjusting to Change / Life Transitions
__Anxiety
__Attachment Issues
__Bereavement
__Bipolar
__Blended Family Issues
__Child and/or Adolescent Issues
__Communication Problems
__Compulsions
__Control Issues
__Creative Blocks
__Depression
__Developmental Disorders (Autism, Aspergers, etc.)
__Dissociation
__Divorce / Divorce Adjustment
__Domestic Violence
__Eating & Food Issues
__Emptiness
__Emotional Abuse
__Emotional Overwhelm
__End-of-life Adjustment
__Family Problems
__Family of Origin Issues
__Grief & Loss
__Habits
__Impulsivity
__Inadequacy
__Infidelity / Affair Recovery
__Isolation (Emotional & Social)
__Life Purpose/Meaning/Inner-Guidance
__Mood Disturbance
__Mood Swings
__Obsessions
__Oppositional & Defiant Behavior
__Panic
__Phobias / Fears
__Physical Abuse
__Post Traumatic Stress
__Relationships & Marriage
__Self-Care
__Self-Doubt
__Self-Esteem
__Self-Harm (Cutting, etc.)
__Sensitivity to Criticism
__Sexual Abuse
__Shame
__Social Phobia/Anxiety
__Stress
__Suicidal (Thoughts, Feelings, and Behaviors)
__Trauma
__Trust Issues
__Violence
__Women's Issues

Other problems/concerns: _____
_____
_____

Emergency Contact Information

Name: _____
Address: _____
Phone: _____ Relationship to you:_____

Insurance Information

Policy Holder's Name: _____ DOB: _____
Policy Holder's address:_____
Relationship to you: _____
Insurance Company Name: _____
ID#_____Group #_____
Deductible: $_____ Has it been met? _____
Copayment (amount *not* covered by your insurance for each visit): $_____
Who will pay noninsured balance? _____
If you are required to get preauthorization, have you done so? _____ # visits authorized: _____
Authorization #_____
Other Insurance
Spouse's Insurance (if any): Name of Plan: _____
Spouse's DOB: _____ Contract #: _____ Group #: _____
Other Insurance Type: _____
Deductible: $_____ Has it been met? _____
Copayment (amount *not* covered by your insurance for each visit): $_____

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

_____

If you do *not* want me to leave a message on your voice mail, please tell me how you want me to reach you by phone:

Signature_____**Date**_____