ALICA FLANAGAN, LICSW

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Please provide the following information below needed for your record. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session.

Name: _____
(Last) (First) (Middle initial)

Age: _____ Birthdate: _____ Gender: ___ M ___ F ___ Transgender

Marital Status: ___ Never Married ___ Married ___ Divorced ___ Separated

___ Widowed ___ Domestic Partnership

Please list any children and ages: _____

Home Address: _____
(Street Number)
_____
(City) (State) (Zip Code)

Phone: _____ ____ yes ____ no
(okay to leave a message)

Email: _____
please note that email is not always a secure form of communication

Who do you live with? _____

Emergency Contact Information:

_____
(Name) (Relation) (Phone #)

Who are your primary supports?

_____

_____

How often do you have contact with your supports?

Daily Weekly Monthly Less than every month

Health and Medical

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

_____

_____

_____

How would you describe your current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

_____

_____

_____

Are you having any trouble with your sleeping or eating patterns (if so, please describe):

_____

_____

_____

Substance use:

___ Alcohol
____ drinks per week

___ Tobacco
___ packs per day

___ Use of illicit substances
___ marijuana ___ heroin ___ cocaine ___ ecstasy/Molly ___ benzodiazepines ___ other

___ Over-the-counter medication

___ Abuse of prescription drugs

Do you think your substance use is a problem?

___ Yes ___ No

Any past problems with drugs or alcohol?

___ Yes ___ No

Occupational and Social

Are you currently employed? ____ yes ____ no

What is your current occupation: _____

Highest level of education

HS grad / GED Some college College degree Postgraduate

Are you currently a student? ____ yes ____ no

Where do you study / what degree are you pursuing? _____

Please list any current legal troubles at this time, if any:

_____

_____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

_____

_____

_____

What do you view to be your strengths as a person?

_____

_____

_____

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.

_____

_____

_____

_____

_____

Are you currently receiving any other mental health services?
___ Yes ___ No

If yes, who with:

(Name) (Phone number)

(Name) (Phone number)

Check here if willing to sign a release of information for communication with the above named provider(s): ☐

Family History
Please list any medical (both physical and mental health) conditions that exist within your family, as well as the family member with the condition:

_____

_____

_____

_____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

_____

_____

_____

Is there any history of suicide in your family? If so, please list:

_____