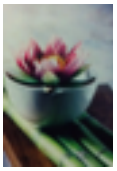

Akira Stuckey, MA, LCMHC
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Protected Health Information

Welcome. Please complete the following form as best you can before our first session (use the back if you need more space). We will discuss the reasons for your coming in when we meet.

Client Name: _____ Today's Date: _____

Gender _____. D.O.B.: _____ Age: _____ Marital/Legal Status _____

Address: _____

Telephone: Home: _____ Cell: _____ Work: _____

Email:_____ Circle if OK to send/leave message.

Employer/ School _____

Emergency Contact Person & Phone: _____

Spouse/Partner (for minor list parents/guardians) Name(s) & Age(s):

_____

Referred By: _____

Insurance Policy Holder: _____

Relationship with the Insurance Holder (Circle one) : Self Spouse/Partner Child

Insurance Information (Carrier, Plan, Group and/or member numbers):

Carrier_____ Plan_____

Member ID Number _____ Group Number _____

Medical Doctor(s): _____ Phone: _____

Address:_____

All current medications & dosages: _____

_____

_____

_____

_____

_____

List any past or present therapies & treatment experiences (practitioners' names, type of treatment, duration, hospitalizations):

Outpatient Treatment:

Date:_____ **Treatment Type** _____

Practitioner's Name _____

Reasons for Treatment _____

_____

_____

Date:_____ **Treatment Type** _____

Practitioner's Name _____

Reasons for Treatment _____

_____

_____

Date:_____ **Treatment Type** _____

Practitioner's Name _____

Reasons for Treatment _____

_____

_____

Hospitalization

Date:_____ **Treatment Type** _____

Facility's Name _____

Reasons for Treatment _____

_____

_____

Date:_____ **Treatment Type** _____

Facility's Name _____

Reasons for Treatment _____

_____

_____

Additional Information: