ASHLEY HUDSON, LCSW, LLC

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New Client Information

Client Information

Who is completing paperwork and relationship to client: _____

Client Name: _____ Date of Birth:_____

Social Security Number:_____

Address: _____

Phone number where I can call, text, or leave messages: _____

Preferred Method for appointment reminders: Call Text Email

Email Address: _____

Emergency Contact Name: _____Phone Number: _____

Relationship to Client: _____

Insurance Information

Insurance Company: _____ Insurance ID number:_____

Insurance Group Number: _____Policy Effective Date: _____

Client's Relationship to Insured: _____

Primary Cardholder Information (If different from client):

Last Name: _____First Name: _____ M.I.: _____

Date of Birth: _____ Social Security Number:_____

Address: _____

Phone: _____

Employer Name: _____

Annual Deductible: $_____ Has deductible been met? Yes No Copay: $_____

Therapy Information

Briefly describe what brought you to therapy:

_____

_____

_____

Previous therapy or mental health care? **Yes** **No**

If yes, for what concern? _____ Was it helpful? **Yes** **No**

Dates that you sought this treatment: _____

Have you ever experienced suicidal thoughts or thoughts of self-harm? Yes No

If yes, when? _____

Do you have any history of substance abuse or addiction? Yes No

If yes, please explain:

_____

_____

What are the outcomes that you would like to experience in your life as a result of our work together?

_____

_____

_____

_____

_____

Health Information

Any important present or past illnesses, injuries or disabilities that you would like to discuss?:

_____

_____

Primary Physician's Name: _____ Date of Last Exam: _____

Are you presently taking any medications? **Yes or No** If yes, please list medication information below:

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Medication: _____ Purpose: _____

Who is your prescribing provider?: _____

Education & Employment

Highest Level of Education:_____

Current Occupation: _____

Employer:_____

Client Signature: _____ Date:_____

Parent or Guardian Signature: _____ Date:_____

Ashley Hudson, LCSW: _____ Date: _____