illuminate
THERAPY & WELLNESS

Your responses to the questions on this form are strictly confidential and will become part of your medical record.

PERSONAL INFORMATION

Name (Last, First, MI):				**Date of Birth:**	
Gender: ☐F ☐M ☐T ☐Other(Specify):				**Preferred Gender Pronoun/s:**	
Address:					
City, State, Zip:					
Home Phone:	**Cell Phone:**		**Email:**		
Preferred method of confidential communication: ☐ Home			☐ Cell		
☐ Email					
Appointment Reminders: Illuminate Therapy & Wellness (IT&W) offers appointment reminders via text message or email. I consent for IT&W to send appointment reminders using: ☐Text /Cell Phone: ☐Email: **I would like to receive email updates from ITW:** ☐Yes ☐No					
Marital Status:	☐Single	☐Married	☐Partner	☐Separated	☐Divorced ☐Widow
Living with:	☐Alone	☐Spouse	☐Partner	☐Roommate	☐Parents ☐Other:
Employment:	☐Full Time	☐Part Time	☐Unemployed	☐Other:	
Student:	☐Full Time	☐Part Time	Grade: _____		
Education:	☐High School	☐GED	☐2 Year College	☐4 Year College	☐Graduate School ☐Other:
Is there a racial and/or ethnic group you identify with that you would like your therapist to be aware of? If so, please list here:					
How did you hear about ITW?					
☐Family/Friend ☐Insurance ☐Physician/Psychiatrist/Hospital Staff ☐School ☐Web Search ☐Other Please provide their name and contact information:_____					
Emergency Contact: Name:		Relationship:		Phone:	
Others you wish to have access to scheduling appointments and/or billing information:					
Name & Relationship:				Phone:	
Name & Relationship:				Phone:	

RESPONSIBLE PARTY

Complete if the Client is a minor OR if someone other than the Client is responsible for payment.

Name (Last, First, MI):			**Date of Birth:**	
Address:				
City, State, Zip:				
Home Phone:	**Cell Phone:**	**Email:**		
Preferred method of confidential communication: ☐Home Phone:		☐Cell Phone:		
☐Email:				
Relationship to Client: ☐Mother	☐Father	☐Legal Guardian	☐Spouse	☐Other (Specify):

Have you been hospitalized and/or received treatment for a psychiatric illness? ☐Yes (Specify):			☐No
Approximate Date(s)	Length of Stay	Hospital/Center	Reason for Admission
Have you ever had suicidal thoughts and/or attempts? If yes, please list the occurrences below:			
Approximate Date(s):			

How did you attempt (method(s)?

PREVIOUS TREATMENT

Have you been to therapy previously? ☐Yes ☐No
If yes, please list approximate dates, reason(s) for seeking treatment, and reason(s) treatment ended:

DESCRIBE YOUR REASON(S) FOR SEEKING THERAPY:

What are your therapeutic goals?
Are you interested in group therapy? ☐Yes ☐No If yes, what kind?
Are you required by a court of law to attend therapy as part of a legal proceeding? ☐Yes ☐No
Other pertinent information you would like your therapist to know: