Brenda J. Arley, MA, RNCS, LMFT
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CONFIDENTIAL PROFILE

(For any part of this form you may use the back, if more room is needed)

TODAY'S DATE:__________________ **REFERRAL SOURCE:**______________________________________

NAME:____ **BIRTHDATE:**___________**AGE**: ________
ADDRESS:____
PHONE #: (H)______________________ (W)_____________________ (CP)__________________________
EMPLOYER:____**OCCUPATION**:______________________
EMPLOYER ADDRESS:____
STUDENT: NO___ YES___ **NAME OF SCHOOL**________________________________**YEARS ATTENDED**______
MARITAL STATUS: Single____; Married___ date_______; Separated ____date_________;
Divorced ___ date________; Widowed___ date_______; Remarried___ date_______;
Domestic Partnership___ date________

HOUSEHOLD MEMBERS: (list below)

Name	Relationship	Birthdate/Age	M/F

FIREARMS (pistols, rifles etc.): Do you possess? No___ Yes___ specify_______________________________
EDUCATION : (highest level completed):_________________________Field of interest__________________________
MILITARY SERVICE: No___ Yes___ please describe____
RELIGIOUS PREFERENCE: No___ Yes___ please describe ___________________________Active___ Inactive____
SPIRITUAL PRACTICES: No____ Yes___ please describe______________________________ Active___ Inactive___
PRIMARY CARE PHYSICIAN (PCP): Name____
Address/phone/fax____
I am not currently receiving services from a PCP/medical practitioner/provider
MEDICAL PROBLEMS: ____________________________________; ________________________________
____________________________________; _______________________________; _____________________________
Prescribed Medications/dosage:_______________________________________;________________________________
________________________________ ;______________________________ ;_____________________________
Name/Address/Phone of Prescribing Provider, if other than PCP: _____________________________
____
Non-Prescribed Medications/dosage:____________________________________;___________________________
________________________________ ;______________________________ ;_____________________________
Other behavioral health practitioner/provider name/address/phone/fax: __________________________
____
I am not currently receiving services from any other behavioral health practitioner/provider
CHEMICAL USE: alcohol ___ tobacco___ caffeine___ marijuana____ cocaine___ other _______________________
How often and how much of each do you use? ____
____
PREVIOUS THERAPY/PSYCHIATRIC HOSPITALIZATION: (with whom/when/where/reasons for)
____
____

NAME: ______________________________ **BIRTHDATE:** __________

CURRENT CONCERN(S)/PROBLEMS and REASON(S) FOR SEEKING THERAPY: ______________________

____

____

CURRENTS SYMPTOMS (check all that apply)

	Feeling depressed		Feeling anxious		Low self-esteem
	Fatigue		Restless		Excessive fear
	Tearful		Worry		Re-living traumatic experience
	Poor appetite		Muscle tension		Sense of foreshortened future
	Sleep difficulties		Impulsiveness		Nightmares/recurrent dreams
	Difficulty making decisions		Excessive daydreaming		Lacking motivation
	Poor concentration		Panic		Easily startled
	Slowed movement		Shortness of breath		Avoiding people/situations
	Decreased energy		Increase heart rate		Loss of sense of identity
	Lack of feeling pleasure		Feeling emotional numbness		Racing thoughts
	Agitation		Fainting		Blackouts/inability to remember
	Irritable		Shakiness		Repetitive behaviors/thoughts
	Feeling worthless		Chest pain		Attempt ignore thoughts/actions
	Feeling guilty		Nausea		Hallucinations
	Social isolation/withdrawal		Hot/ cold sweats		Delusions
	Suicidal thoughts		Fear of death/of going crazy		Risky behaviors
	Suicidal intention/plan		Hypervigilant		Manic mood
	Sexual difficulties		Fear of gaining weight		Over/under eating
	Weight gain or loss		Excessive exercise		Lacking close friends
	Prefer to be alone		Recurring suspicions		Excessive devotion to work
	Preoccupied with details		Difficulty expressing disagreement		Reluctant to take personal risks

INSURANCE INFORMATION

Photocopy of insurance card provided: Yes___ No___ If not, please complete information below:

Primary Insurance

Insurance Company Name:______________________________

Insurance claims address: ______________________________

Member's Name:______________________ Date of Birth: ______________

Member's ID#:______________ Group#:__________ Member's SS#:______________

Member's Employer: ______________________________

Secondary Insurance

Insurance Company Name:______________________________

Insurance claims address: ______________________________

Member's Name:______________________ Date of Birth: ______________

Member's ID#:______________ Group#:__________ Member's SS#:______________

Member's Employer: ______________________________

AUTHORIZATIONS

I authorize **BRENDA J. ARLEY, MA**, **RNCS, LMFT** to release any medical or other necessary information to process insurance claims.

I authorize payment of medical benefits to **BRENDA J. ARLEY, MA, RNCS, LMFT.**

I authorize **BRENDA J. ARLEY, RNCS, MA** to acknowledge my participation in therapy to the **referring professional** (note this refers to a professional other than your PCP)

Not applicable

Client Signature______________________________ Date______________