LEE JACOBS RIGGS, LPC, LCPC
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The following information is confidential and will not be shared, unless you choose to release this information to someone else. If there are questions you prefer not to answer, you may leave them, however, your answers to these questions will help me to better serve you.

Date _____ **First Name**_____ **Last Name**_____

Gender Pronoun_____

Age ____ **Date Of Birth** _____

Address	**City**	**State**	**Zip**

May I contact you via mail at the above address? ☐ Yes ☐ No

Home Phone	☐ Yes ☐ No May I leave a detailed message?	**Email**	☐ Yes ☐ No May I contact you by e-mail?

Name of contact person in the case of emergency _____

Relationship of person to you _____ **Phone Number** _____

1. Have you previously been in counseling? ☐ Yes ☐ No

If "Yes", please list approx. dates: _____

_____

2. OTHER CURRENT PROVIDERS: (List names of any other mental health, psychiatric, or supportive services you're receiving now)

_____

_____

3. MEDICAL AND/OR PSYCHIATRIC HOSPITALIZATIONS: (List dates, conditions and treatments when possible)

_____

_____

4. CURRENT MEDICATIONS AND CONDITIONS TREATED: (Include birth control pills, over the counter medications, herbal/holistic/alternative remedies, as applicable) _____

_____

5. HABITS: Smoke – Number of cigs_____/day/week **Alcohol –** Number of drinks _____/day/week/month

Sleep – Number of hours_____/night **Caffeine –** Number of cups tea/coffee _____/day/week

Diet/concern re: eating:_____
Exercise type and amount:_____
Other drug use:_____

6. Do you have health insurance? ☐ Yes ☐ No If yes, what plan?_____