54 Sugar Creek Center Blvd
Suite 200
Sugar Land, TX 77478
Office: 281-494-9100
Fax: 281-494-9115
terri.lively@comcast.net

Sugar Creek Psychotherapy
Terri Lively, LCSW

www.sugarcreekpsychotherapy.com

Scheduling: 832-895-0072 or
scheduling@sugarcreekpsychotherapy.com

Confidential Information Sheet

Date: _____

Name	_____ Last	_____ First	_____ MI	Home Phone	_____
				Work Phone	_____
Address	_____ Street	_____ City	_____ State	Cell Phone	_____
			_____ ZIP	Email	_____

Please **DO NOT** contact me by (check all that apply)	☐ Home Phone	☐ Work Phone	☐ Cell Phone	☐ Email
My preferred method of contact is	☐ Home Phone	☐ Work Phone	☐ Cell Phone	☐ Email

Age	_____	Marital Status	☐ Single	☐ Separated	☐ Widowed
Birthdate	_____		☐ Married	☐ Cohabitated	☐ Divorced
Social Security #	_____				

Are you currently employed?	☐ Yes	☐ No						Occupation	_____		
Company Name	_____										
Education: Check Highest Level Completed	High School				College				Post Graduate		
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4

Spouse's Name	_____							Occupation	_____		
Age	_____							Years Married	_____		
Birthdate	_____										
Social Security #	_____										
Education: Check Highest Level Completed	High School				College				Post Graduate		
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4

Your Prior Marriages	Spouse's Prior Marriages
From _____ To _____	From _____ To _____
From _____ To _____	From _____ To _____
From _____ To _____	From _____ To _____

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Confidential Information Sheet (continued)

Who referred you to Terri?	Name	Relationship	May Terri thank this person for the referral? **Y/N**
Person to Contact in Emergency	Name	Relationship	Phone #

What issues brought you to therapy today? _____

What are your goals through psychotherapy? _____

Have you ever been in psychotherapy? ☐ Yes ☐ No

If yes, with whom and when? _____

Was it helpful? _____

Have you ever been hospitalized for a mental or emotional problem? ☐ Yes ☐ No

If yes, where and when? _____

List any medications you are taking: _____

Who prescribed these medications? _____

Do you have any significant physical problems? ☐ Yes ☐ No

If yes, what are the problems? _____

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Family History

Where did you grow up?

_____

	Mother	Father
Living or deceased?	☐ Living ☐ Deceased	☐ Living ☐ Deceased
If living, how old? If deceased, when did he/she die?	_____	_____
Quality of relationship	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list the names and ages of brothers and sisters and rate the quality of your relationship with each:

Name	Age	Quality of Relationship
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you have children, please list names and ages of each:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Is there any history of mental or emotional problems in your immediate or extended family?

_____

Is there any history of drug or alcohol addiction or abuse in your family?

_____

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Patient Insurance Information

Insurance Company		ID or Member #	
Phone # of Insurance Company		Group #	
Address of Insurance Company	Street	City	State ZIP

Patient's relationship to Insured		Full time student? ☐ Yes ☐ No	
Primary Insured Name			
Primary Insured Address	Street	City	State ZIP
Primary Insured SS#			
Primary Insured Employer			

Release of Information and assignment of benefits

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the therapist who accepts assignment for services.

Signed: _____ Date: _____

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