Tranquil Minds
Behavioral Health
*Heather M. Gibbon, LLC*
7738-B Madison Boulevard
Huntsville, AL 35806
(256) 224-4755

# Registration Form

Please fill in the information below and bring it with you to your first session.
Please write legibly and complete all sections.
Please note: information provided on this form is protected as confidential information.

## Personal Information

Name: _____ Date: _____

Social Security Number: _____ DOB: _____ Age: _____ Gender: _____

Emergency Contact Name and Telephone Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Parent/Legal Guardian (if under 18): _____

Martial Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): _____

## Responsible Party Information (If different from Client)

Name: _____ Relationship to Client: _____

Social Security Number: _____ DOB: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _(____)_____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _(____)_____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

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## Insurance Information

### Primary Insurance

Insurance Company: _____ Employer: _____

Policy#: _____ Group#: _____ Effective Date: _____

Name of Insured: _____ Relationship to Client: _____

Social Security Number of Insured: _____ DOB: _____Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

### Secondary Insurance

Insurance Company: _____ Employer: _____

Policy#: _____ Group#: _____ Effective Date: _____

Name of Insured: _____ Relationship to Client: _____

Social Security Number of Insured: _____ DOB: _____Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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# Client Intake Questionnaire



## History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list: _____
_____
_____

Have you ever been prescribed psychiatric medication other than any listed under current? □ Yes □ No

If yes, please list and provide dates: _____
_____

## General and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____
_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: _____
_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____
_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

**Client Intake Questionnaire**



Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage in recreational drug use? (Circle one)

Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently? _____

_____

**Family Mental Health History**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.) or note "self".

| | Please Circle | List Family Member(s) or Self |
|---|---|---|
| Alcohol/Substance Abuse | yes / no | |
| Anxiety | yes / no | |
| Depression | yes / no | |
| Domestic Violence | yes / no | |
| Eating Disorders | yes / no | |
| Obesity | yes / no | |
| Obsessive Compulsive Behavior | yes / no | |
| Schizophrenia | yes / no | |
| Suicide Attempts | yes / no | |

**Client Intake Questionnaire**



**Additional Information**

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? □ No □ Yes

Is there anything stressful about your current work? _____

_____

What is your employment history? _____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

_____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

What would you like to accomplish during your time in therapy? _____

_____

_____

How will you know when you have completed therapy? _____

_____

_____