VERUS
THERAPY

For whom are you seeking treatment? Self Child Other

How did you hear about us? *(Circle all that apply)*

PsychologyToday Website School Google Friends goodtherapy.org

Which services are you interested? *(Circle all that apply)*

Psychotherapy Couples Therapy Assessment For Bariatric Surgery

Adult Or Parent Personal Information Below

Name:

Age: Date Of Birth:

Email: Gender:

Home Phone: Cell Phone:

Can we communicate with you via text message? yes or no

Can we leave you voicemails? yes or no

Address:

City: State: Zip:

Occupation:

Employer:

Relationship Status: Married Single Divorced Other

Emergency Contact Name:

Emergency Contact Number:

Reason For Seeking Services:

Information Regarding Minor Child Below

Name:

Age: Date Of Birth:

Email: Gender:

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Information Regarding Spouse Or Partner

Name:	
Age:	Date Of Birth:
Email:	Gender:
Occupation:	

Safety & Risk Assessment

Have you ever been diagnosed with a mental illness? *(Please Circle.)*	Yes No Other
If yes, please list your diagnosis.	
If other, please explain.	
Are you currently experiencing overwhelming or intense anxiety or agitation?	yes or no
Have you ever been hospitalized for mental health reason?	yes or no
Do you currently have thoughts or plans to end your life?	yes or no
Have you had thoughts to end your life?	yes or no
Has anyone in your immediate or extended family ever completed suicide?	yes or no

Consent, Agreement & Policy Information

I consent to the limitation on confidential communication.	I consent or I do not consent
I have read and understand the service agreement and office policy.	I agree or I do not agree
I have received and acknowledge the notices of privacy statement.	I acknowledge or I do not acknowledge
Name:	
Signature:	
Date:	