Ryan Gillespie, Ph.D., HSP
2200 21st Ave. South, Suite 229
Nashville, TN 37212

P:615-788-9831
F:615-298-3011
gilleryan@gmail.com

Please provide the following confidential information. Please Print.

Today's Date_____

Client

Name_____**Preferred Name**_____
First Middle Last

Address_____
Number Street City State Zip

Home #_____**Cell #**_____**Work #**_____

Social Security Number: _____

Date of Birth_____**Age**_____ **Sex:** _____

Employer_____**Job Title/Occupation**_____

Work Address_____
Number Street Suite# City State Zip

Religious Affiliation or Spiritual Practice_____

Primary Care Physician_____**Date of Last Exam**_____

Psychiatrist (if applicable)_____**Date of Last Appointment**_____

Relational Status: Single Partnered Married Committed Separated Divorced Widowed Other

Length of Current Relationship_____

Dates of Previous Marriage(s)/Committed Relationship(s):_____

_____

Dependent(s) Names/ Age(s)_____

_____

Who may I thank for referring you:_____

Briefly Describe Your Reasons for Seeking Counseling:_____

_____

_____

_____

_____

_____

My symptoms include (place a check mark next to all that apply):

Sadness____
Insomnia____
Hypersomnia____
Crying spells____
Suicidal Thoughts____
Decrease in pleasure____
Fatigue/no energy____
Difficulty concentrating____
Anxiety/fear/worry____
Hopelessness____
Helplessness____
Excessive/inappropriate guilt____
Irritability____
Changes in appetite____
Decreased self-esteem____
Relationship difficulties____
Troubling or racing thoughts____
Paranoia____
Feeling out of control____
Thoughts of harming others____
Confused or forgetful____
Drug/alcohol use/abuse____
Panic attacks____
Indecisiveness____
Impulsivity____
Other:_____
Self-injury____
Eating Disorder/Body image____
Academic/Occupational difficulties____

Physical Symptoms:_____

Please List Goals (as many you would like) for Current Counseling:_____

Prior Outpatient Treatment (Other mental health professionals you have worked with; add dates if possible):_____

Inpatient Psychiatric Treatment: Yes____ No_____ If yes, please list dates, location, and reason for admission:_____

Medical Problems or History of Medical Problems: Yes____ No____ If yes, please describe:_____

Current Medications & Dosage (Prescription/Herbal/Other): **Prescribed by**:_____

List medication names:_____

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Has anyone in your family (blood relatives) ever been diagnosed with a mental illness? Yes____ No____

If yes, please indicate your relationship to this person(s) and diagnosis (if known):_____

_____

_____

_____

Has anyone in your family ever attempted/committed suicide? Yes____ No____

If yes, please indicate your relationship to this person(s) and any additional information you can offer:_____

_____

_____

_____

Any Additional Information (add any additional information you feel is relevant to your reasons for seeking counseling):

_____

_____

_____

_____

_____

Emergency Contact(s):

Name(s)_____**Relationship(s)**_____

Day Telephone #_____**Evening #**_____

Address_____
Number Street City State Zip

Name(s)_____**Relationship(s)**_____

Day Telephone #_____**Evening #**_____

Address_____
Number Street City State Zip

Payment Information

Financially Responsible Party: Self_____ Other_____ If Self, Give Billing Address Below:

Same as Previously Given_____, or:

Address_____
Number Street City State Zip

If Financially Responsible Party Is Not the Client, Please Provide the Following Information:

Responsible Party's Name_____
First Middle Last

Relationship to Patient_____

Billing Address_____
Number Street City State Zip

Home #_____**Cell #**_____**Work #**_____

Employer_____**Job Title/Occupation**_____