Client Information

Name:_____ Date:_____

Address:_____ Employer:_____

_____ Work Phone:_____

Home Phone:_____ Occupation:_____

Birthdate:_____ Relationship Status:_____

Social Security #:_____ Email:_____

Emergency Contact:_____

(will only contact in event of an actual emergency)

Phone Number:_____

Primary Insurance Information

Name of insured:_____ Relationship to insured:_____

Address (if different than your address/phone): Insured Employer:_____

_____ Insurance Co: _____

_____ Plan name:_____

Home Phone:_____ Insured's ID #_____

Birthdate:_____ Policy Group #_____

Authorization to Release Information:

I authorize the release of any medical or other information necessary to process insurance claims.

_____

Signature Date

Authorization to Pay Benefits to Provder:

I authorize payment of benefits directly to the therapist for the services provided.

_____

Signature Date

Who referred you to me?_____

Previous counseling/treatment?

Was it helpful?

What brings you to counseling?

How long have you had this problem?

Why are you seeking help now?

What other ways have you tried to deal with this problem?

What are your goals for counseling?

Who lives with you? (use back if necessary)

Name	Age	Relationship

Medical Information:

Primary Care Physician:_____phone #_____

Psychiatrist (if you have one):_____phone #:_____

Current Medications:

Medication and dosage	Reason for taking	How long have you been taking this medication?

Medical Conditions:_____

_____

_____

Have you had any major injuries (especially head injuries):_____

_____

How often do you use alcohol?_____

Do you use any other drugs?_____

Family History of emotional problems:_____

_____

_____