Completion of this form and signature ***required.***

CLIENT INFORMATION

Name _____ Date _____

Signature _____ Nickname _____

SSN _____ Gender _____ Age _____

Referral (such as Google, webpage, friend) _____

Birth date/year _____ Age _____ Birthplace_____

Home address _____

City/State/Zip/or Country _____

Home phone _____ OK to call/leave message? YES NO

Cell phone _____ OK to call/leave message? YES NO

Occupation/Job title _____ Employer_____

Business phone _____ OK to call/leave message? YES NO

In case of *emergency*, contact _____@_____

Do you plan to submit insurance claims for sessions? YES NO

(***Note***: You will pay session fees by **cash/check** *at time of service* and will be given a signed super bill to submit to your insurance carrier. This office does *not* guarantee reimbursement by your insurance carrier.) *Initials here* _____

Have you ever been in counseling before? YES NO When? _____

Name of Counselor(s)? _____ For what problem(s)? _____

_____

Currently seeking help about what problem(s)? _____

_____

Current medications (For? Dosage? How long? Prescribing doctor(s)?) _____

_____

_____

Circle one: *Single Living together Married Separated Divorced Widowed*

How many times married? _____ How many children/ages _____

Current partner's name _____ His/Her age _____

If *separated* from partner/*divorced,* for how long? _____

How long married before *widowed*/since partner's death/ cause of death?

_____

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