CLIENT & BILLING INFORMATION

Client Name:____Today's Date:_________________

Address:____________________________________City, State, Zip:___________________________

Primary phone where messages may be left:_____________________________(cell,home, or work?)

Alternate Phone:______________________________ (cell,home, or work?) Messages ok?__________

E-mail:____________________________May we e-mail or text you regarding appointments?______

Gender: M____F____Age:_______Date of Birth:_________________Marital Status:_____________

Education:_________________________________Occupation:_________________________________

Social Security #:_________________________Referred by:________________________________

Others living in the home (Name, birthdate, relationship to client):

Emergency Contact Name & Phone:____

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Partner's Name (if being seen as a couple):____

Partner's phone where messages may be left:____________________________ (cell,home, or work?)

Partner's age:_____________Date of Birth:______________________Gender: M_____F______

Education:_________________Occupation:_______________________SSN____________________

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Insurance Information: Please provide if the subscriber is different than the client.

Name of Subscriber:____Date of Birth______________

Address of Subscriber if different than client:____

__________________________________Relationship of client to subscriber:______________________

We will photocopy your insurance card if available. If not, please provide the following information.

Insurance Company:____Phone:___________________

ID #____Group #_________________________________

Secondary Insurance Information:

Name of Subscriber:____Date of Birth______________

Address of Subscriber if different than client:____

__________________________________Relationship of client to subscriber:______________________

We will photocopy your insurance card if available. If not, please provide the following information.

Insurance Company:____Phone:___________________

ID #____Group #_________________________________

Client or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Print Name:_________________________Signature:____________________________Date_________

Print Name:_________________________Signature:____________________________Date_________

Intake Information: History **Client Name:**

Describe the problem(s) that brought you here today:

Check any of the symptoms that you are having:

[] Extreme Sadness
[]Trouble Concentrating
[]Memory Problems
[]Change in eating habits
[]Feeling of extreme hapiness
[]Trouble performing you job
[]Lack of enjoyment of usual activities
[]Self-esteem problems
[]Perfectionism
[]Obsessions or compulsions
[]Worries
[]Physical complaints of pain
[]Problems with anger
[]thought of hurting yourself or others
[]Seeing/hearing things that are not there
[]Other, please list below
[]Feeling hopeless
[]Feeling tearful
[]Sleep problems
[]Lack of energy
[]Too much energy
[]Weight changes
[]Feeling stressed
[]Easily irritated
[]Feeling guilty
[]Concerns about substance abuse
[]Sudden feelings of panic
[]Muscle tension
[]Acting violently
[]Thoughts of killing yourself or others
[]Concerns about pornography

Intake Information: History **Client Name:**

Counseling History:

Have you ever been in counseling before?
If "yes", please describe below, starting with the most recent time first.

NAME OF PROVIDER: **DATE(S) OF SERVICE:**
EXPLAIN WHAT HAPPENED:

NAME OF PROVIDER: **DATE(S) OF SERVICE:**
EXPLAIN WHAT HAPPENED:

Medical Information:

Have you seen a doctor within the last year?

Why have you seen a doctor?

Doctor's Name: **Phone:**

Are you taking any medications, prescription or over-the-counter?

Do you have allergies to anything?

Please describe allergy problems that you may have:

Substance Use History:

Do you use/have you used tobacco (any form)? **Current [ ] Past [ ] No [ ]**
Do you use/have you used alcohol? **Current [ ] Past [ ] No [ ]**
Do you use/have you used caffeine (any form, including soda drinks)? **Current [ ] Past [ ] No [ ]**
Do you use/have you used recreational drugs? **Current [ ] Past [ ] No [ ]**