

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

- May I have your permission to thank this person for the referral?
 Yes No
- If referred by another clinician, would you like for us to communicate with one another?
 Yes No

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

What are your goals for therapy? _____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

**The following information on this form will help guide your treatment.
Please try to fill out as much as you are comfortable disclosing.**

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): _____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

Height _____ Weight (if applicable) _____ Age _____ Gender _____

Sexual & Gender Identity: Heterosexual Lesbian Gay Bisexual Transgender
 Asexual In Question Other: _____

Racial/Ethnic Identity:

African/African-American/Black Latino/Latino-American Bi-Racial/Multi-Racial
 American Indian/Alaska Native Middle Eastern/Middle Eastern-American
 Asian/Asian-American/Asian Pacific Islander White/European-American Not listed

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? _____ How Long? _____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships _____

Do you have Children? _____ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

Please briefly describe any history of abuse, neglect and/or trauma: _____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: _____

Is spirituality important in your life and if so please explain: _____

Briefly describe your diet and exercise patterns: _____

EDUCATION & CAREER

High School/GED ___ College Degree ___ Graduate Degree(or Higher) ___ Vocational Degree ___

What is your current employment? _____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant? _____

What do you think are your strengths? _____

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				“Nervous Breakdown”			

Any additional information you would like to include:

**Primary Insurance Information and Benefit Verification Worksheet and
Consent to Treatment**

Patient Name _____

DOB of Patient _____ SS# of Patient _____

Insurance Provider _____ Effective Date _____

Policy Number _____ Group Number _____

Name of *Primary* Insured (if different from patient) _____

Employer of *Primary* Insured _____

DOB of *Primary* Insured _____ SS# of *Primary* Insured _____

Phone Number for Mental Health Services _____

Name of Insurance Rep with whom you spoke and date you spoke with them _____

Are Authorizations required? Yes No

Number of sessions authorized _____

Authorization Number(s) _____

CPT Code(s) _____

Start Date _____ End Date _____

Copay _____ Deductible _____

Has the deductible been met for this year? Yes No

Maximum Visits per Year _____

What is the specific address for Mental Health Claims (this address is usually different from the general medical claims address on your insurance card)

Counseling and Development Inc. is required by law to collect all co-pays at the time of service. There will be a \$25.00 service charge for any unpaid/returned checks. Please note: we do not file secondary insurance unless required to do so by federal law.

If you have insurance that requires preauthorization, you must notify your clinician of any changes in your insurance coverage and benefits before each visit. It is your responsibility to ensure that your visits are fully authorized by your insurance company. By law, we cannot bill your insurance for missed appointments. You are responsible for the full payment of all appointments not cancelled with at least 48-hour notice.

I hereby authorize all information necessary for the purpose of authorizing and processing my claims to be released to my insurance company. I understand this information may include diagnoses, dates of service, charges, symptoms, and treatment recommendations. I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company. I understand that I will be charged \$100.00 for any appointments not kept unless at least a FULL 48-HOUR notice (a 72-hour notice is required if cancellation is for a Monday appointment) is given to the clinician.

I consent for treatment necessary for the care of the above-named patient. I have read, understand, and agree to the office policies, attached.

Signature of Patient or Guardian

Date
