INDIVIDUAL CLIENT INFORMATION QUESTION

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully.

REFERRED BY_____**Date:**_____

Client's Name: _____
First Middle Last

Address: _____
Number Street City State Zip

SS#:_____ Birthday: _____ Sex: ☐ Male ☐ Female ☐ Marital Status: ☐ Single ☐ Married ☐ Seperated

Phone (Work):_____ Phone (Home):_____ Phone (Cell):_____

Relationship to insured: (select one) ◯ self ◯ spouse ◯ child ◯ step-child ◯ adopted child ◯ foster child ◯ other _____

Marital Status of family ? ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Other_____

If divorced who has custody ? _____

Employer: _____ Phone (Work):_____

Insured Name:_____
(if different from client) First Middle Last

Address: _____

SS#:_____ Birthday: _____ Sex: ◯ Male ◯ Female

Phone (Home):_____ Phone (Cell):_____ Phone (Work): _____

Employer:_____

Briefly describe your reason for seeking help:
_____
_____
_____

List any major health problems for which you currently received treatment:
_____
_____

List any medications you are now taking:
_____
_____

Have you ever received psychiatric or psychological help or counseling of any kind before? ◯ YES ◯ NO
If yes, please explain:
_____
_____
_____

List the members of your family and all others in your home:

Name Age Relationship Occupation

_____
_____
_____
_____
_____
_____
_____

If you believe insurance may cover a portion of your visits here, please complete the following information:

Primary Care Physician: _____Phone_____

Address: _____
Number Street City State Zip

Health Plan: _____

Address: _____
Number Street City State Zip

Phone:_____ID#_____Group# _____

Secondary Health Plan: _____Phone_____

Address: _____

ID#_____Group#_____

If this is a **Employee Assistant Program** ◯ NO ◯ YES

Company Name_____Phone_____

I agree to attend all scheduled sessions unless I cancel at least 24 hours in advance. I understand that failure to cancel one day prior to my appointment will result in my being charged $60.00 for that session. Regardless of insurance coverage, I understand that I am responsible for all fees incurred.

SIGNED: _____DATE:_____