# CLIENT INFORMATION FORM

****PLEASE COMPLETE EACH AREA. ALL PAPERWORK MUST BE COMPLETED BEFORE ARRIVING FOR YOUR APPOINTMENT. INCOMPLETE PAPERWORK MAY RESULT IN NOT BEING SEEN AS SCHEDULED.**

**Client Name:** _____ **(Nickname):** _____
First Middle Last

**Client Address:** _____
Street City State Zip

**Mailing Address, if different:** _____
P.O. Box / Street City State Zip

**Client Cell Phone:** _____ **Can we text you**? ☐ Yes ☐ No **Cell Provider**_____
(AT&T, Sprint, Straight Talk, Verizon, etc)

**Home Phone:** _____ **Other:** _____ **Email:** _____

**Appointment Reminder via:** ☐ Email ☐ Phone call ☐ Text **Preferred number to call or text** ☐ Cell ☐ Home ☐ Other

**SS#:** _____ **Date of Birth:** _____ **Age:** _____ **Sex:** ☐ M ☐ F ☐ U

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

| Marriages | Year Married | Year Separated/Divorced | Reason for Marriage Ending |
|---|---|---|---|
| First | | | |
| Second | | | |
| Third | | | |

**If married and/or currently living with someone, for how long?** _____

**How would you describe this relationship?** ☐ Great ☐ Good ☐ Fair ☐ Poor

**List all Household members (Names, ages, and relationship to you):** _____

_____

_____

**List any children <u>not</u> living with you (Names & Ages):**_____

_____

## CLINICAL INFORMATION: *Please fill in the following information as completely as possible. All information is covered by our confidentiality policy. Use a separate sheet of paper if necessary.*

**Describe what led you to seek counseling now**:_____

_____

_____

**Check current concerns and symptoms:**

| | | | | |
|---|---|---|---|---|
| ❑ Depressed Mood | ❑ Irritability | ❑ Poor Concentration | ❑ Difficulty sleeping | ❑ Tired |
| ❑ Suicidal Thoughts | ❑ Panic Attacks | ❑ Worry | ❑ Nightmares | ❑ Stress |
| ❑ Family Conflict | ❑ Using Alcohol | ❑ Using Illegal Drugs | ❑ Hurting self | ❑ Temper Outbursts |
| ❑ Obsessive Thoughts | ❑ Compulsive Behaviors | ❑ Other: _____ | | |

**When did the above symptoms begin?**_____

**Some people desire faith-based elements incorporated in their treatment, is this something you are interested in?** ☐ Yes ☐ No ☐ Doesn't matter

**Please list any substances that you use.** ***Include amount and frequency:***

Alcohol _____ Marijuana _____ Caffeine _____
Tobacco (cigarettes, etc.) _____ Heroin _____ Other _____
Psychedelics _____ Methamphetamine _____

**** Do you have thoughts about hurting yourself or others?** ☐ No ☐ Yes **If yes, please describe.**

_____

***<u>Please complete other side</u>***

**Please describe your goals for therapy:**

**A.** _____

**B.** _____

**C.** _____

**Briefly describe your strengths and weaknesses:**

_____

_____

**Are you currently on any psychiatric medication?** ☐ Yes ☐ No

| Medication | Dosage | Prescribing Physician | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Any psychiatric medications you have taken in the past (and are not currently taking):**

| Medication | Prescribing Physician | Date Started | Date Ended |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.)**

_____

_____

**Has anyone in your immediate or extended family had a psychiatric illness? Please list relationship and nature of illness.** _____

_____

## MEDICAL INFORMATION:

**Primary Care Physician:** _____ **Phone:** _____

**Date of last exam:** _____

**Medical History.** Please list major injuries, illnesses or surgeries:

| Condition | Dates | Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## DEVELOPMENTAL INFORMATION:

**What was your family like growing up? For example instances of parental substance abuse, physical, verbal or sexual abuse issues, accidents, notable positive events, as well as other relevant life events:**

_____

_____

_____

_____

**Briefly describe your current support system (family, friends, organizations, self):** _____

_____

***Please complete other side***

**Education:** _____

**Current employer:** _____
Name of Employer Location Phone #

**Work History Summary**

_____

_____

**Have you ever been arrested?** ☐ No ☐ Yes

**Estimated number of arrests**: _____ **Total time jailed / imprisoned**: _____

**Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc.), which may involve your therapist?** ☐ Yes ☐ No **If yes, please describe *(Use a separate sheet of paper if necessary)*:** _____

_____

_____

***We require you to provide the name and phone number for a person we can contact in an emergency:***

**EMERGENCY CONTACT:**_____ **PHONE #:**_____

**INSURANCE INFORMATION**:

**PRIMARY INSURANCE**

INSURED NAME: _____

BIRTHDATE: _____

INSURANCE CO: _____

POLICY # _____

GROUP # _____

CLAIMS ADDRESS: _____

INS. CO. PHONE: _____

**SECONDARY INSURANCE**

INSURED NAME: _____

BIRTHDATE: _____

INSURANCE CO: _____

POLICY # _____

GROUP # _____

CLAIMS ADDRESS: _____

INS. CO. PHONE: _____

**MEMO OF UNDERSTANDING**:

- ***I voluntarily consent to be seen in treatment by the clinical staff at New Life Counseling.***
- I understand that I am responsible for all fees charged for services and understand that co-pays, deductibles or balances are due at the time the services are rendered.
- I understand that if I have insurance, New Life Counseling will bill my insurance company and make every attempt to collect payment from my insurance company. I understand that there are fees for services that may not be covered by insurance. An example of the fees not covered by insurance are phone calls with my clinician, reports or letters written by my clinician on my behalf, non-covered testing fees, and late cancel or no show fees.
- I agree to pay, at the time of service, for any fees that New Life Counseling cannot bill to insurance and I further understand that I am fully responsible for payment of any fees that my insurance company declines to reimburse.
- I agree that if there is any change in my insurance that I will notify New Life Counseling immediately of those changes.
- I further understand that I am ultimately responsible for the balance on this account for any professional services received and that payment is due at the time of service.
- ***I understand that if I do not show for an appointment or if I cancel an appointment within 24 hours of my scheduled appointment time, I will be assessed a $75 fee that is not insurance billable or reimbursable.***

_____

**Client Name (Print)** **Date** **Client Signature**

_____

**Guardian/Other (Print)** **Date** **Guardian/Other Signature**