Date__________________ Referred by____ Insurance ID# _____________

Patients Name__________________________________ Date of Birth_________________ Age________ Male Female

Address____City____________________State_________Zip_________

Phone: Home___________________Cell___________________Work___________________Marital Status___________

Employer___________________________ Children (Name & Age)____

Spouse Name_______________________ Employer_________________________ Spouse Phone___________________

Previous Counseling__________________________ Education_______________ Primary Physician_________________

Emergency Contact_____________________ Phone (C)___________________ (W)_________________(H)___________

Check any items that apply to you

__Depression	__Shame	__Substance Abuse	__ Anger	__Impaired Judgment	__Elevated Mood
__Anxiety	__Child Abuse	__Fear	__Guilt	__Helplessness	__Hyperactivity
__Self Doubt	__Obsessions	__Impulsiveness	__Panic Attacks	__Compulsions	__Relationship Issues
__Delusional	__Withdrawn	__Grief/Loss Issues	__Irritability	__Oppositional	__Paranoia
__Binging	__Purging	__Distractibility	__Grandiosity	__Sleep Disturbance	__Decreased Energy
__Marital	__Parenting	__Family Conflict	__Work Issues	__Worthlessness	__Depressed Mood
__Sex Offender	__Concentration	__Somatic Complaints	__Dissociative	__Domestic Violence	__Learning Disability

Symptoms present for: ___1 mo ___ 1-6 mo ___ 7-12 mo ___ 1yr

Substance Abuse (including substance, amount and frequency) ____

____

__Suicidality __Not Present __Ideation __Plan __Means __ Prior Attempt

Medications (dosage & frequency)____

ARRIVE TEN (10) MINUTES BEFORE YOUR SCHEDULED APPOINTMENT; OTHERWISE, YOUR APPOINTMENT MAY HAVE TO BE RESCHEDULED. SESSIONS ARE 45-TO-60 MINUTES.

Insured's Name ____________________ Insured's Insurance ID#________________ Insured's SS#__________________

Insured's Date of Birth_____________ Insured's Cell Phone__________________ Work_____________ Home_________

Insured's Employer ______________________Insured's Address____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIM PAYMENTS Signature__________________________________ Date____________________

I understand I am financially responsible for all charges for services to the counselor, including the balance remaining after payment of possible benefits and if the Insurance does not pay. Signature______________________________

I Understand I will be billed for half the fee No Shows and failure to cancel in 24 hours:

Signature __________________________________ Date _________________