



This form will enable us to gain a quicker understanding of you and it will become a part of your confidential file. Please answer each question as completely as possible. If you are a couple, please fill out two forms, one for each person.

Date _____

PART I: CLIENT

Name _____ Age _____ Sex _____
First Middle Last

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Pager _____ Cell Phone _____

Date of birth _____ SS# _____

Marital Status: Single _____ Married _____ (# of years _____) Divorced _____

(How long? _____) Separated _____

Occupation _____ Total hours/week _____

Employer (or school) _____ Full-time Part-time

Address of employer _____

Primary Care Physician (PCP) _____

Address _____ Phone _____

Please list any over-the-counter medicines or prescribed medicines you are taking currently (herbs, supplements, etc.), including the dosages _____

Family member to notify in case of emergency _____

Emergency contact phone number _____

Who gave you my name? _____

May I have your permission to thank this person for your referral? Yes No

Do you expect to be involved in any legal action where your counselor's
documentation or testimony will be required? Please explain. _____

Religious Affiliation _____ Church _____

Active _____ Inactive _____

PART II: INFORMATION ON SPOUSE AND CHILDREN

Spouse's Name _____ Birthdate _____ SS# _____

Employer of Spouse _____

Address of Employer _____

Medications spouse is currently taking _____

Names and ages of children _____

Concern's Check List

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Depression | <input type="checkbox"/> Education | <input type="checkbox"/> Eating difficulties |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Physical problems | <input type="checkbox"/> Social relationships | <input type="checkbox"/> Problems with children | <input type="checkbox"/> Abuse |
| <input type="checkbox"/> Problem with parents | <input type="checkbox"/> Spiritual concerns | <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Trouble making decisions | <input type="checkbox"/> Unhappy most of the time | <input type="checkbox"/> Use of alcohol | <input type="checkbox"/> Use of other drugs |
| <input type="checkbox"/> Work | <input type="checkbox"/> Worry | <input type="checkbox"/> Other (Specify) _____ | |

FINANCIAL INFORMATION SHEET

If you have any financial questions or concerns about your fee, please talk to your therapist. Fees or copays are due at time of service. You may use check, cash, Visa or MasterCard.

PART A

Total gross family income _____ # of dependents _____

Who is financially responsible for these fees? _____

Do you have insurance? _____

We will file your insurance if we are on your panel. If we are not on your panel, please check with your therapist to see if your company is one that we file with.

PART B

Is your therapist a part of your managed care plan? Yes No I Don't Know

Primary Insurance Company _____

Address _____

Phone Number of Insurance Company _____

Policy # _____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Date of Birth _____

Insured's Employer _____

Secondary Insurance Company _____

Address _____

Phone Number of Insurance Company _____

Policy # _____ Group # _____

Insured's Name _____ Insured's SS# _____

Insured's Date of Birth _____

Insured's Employer _____

I, the undersigned, do authorize the release of any medical information necessary to process claims. I hereby assign payments directly to Paraclete Counseling Center and the supervisors thereof of the benefits as well as major medical benefits herein specified, and otherwise payable to me under the terms of my insurance. I understand that I am financially responsible to the clinician for charges not covered by this agreement. I hereby authorize photocopies of this form to be as valid as the original. Given under my hand and seal this _____ day of _____, 20____; in the city of _____, situated in _____ county, state of Georgia.

Signed _____ Date _____