EIRENE COUNSELING SERVICES, INC.

Client Information Form

For office use only

Date: _____
Client's number: _____
Counselor: _____

CLIENT INFORMATION

Name: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ Email: _____

Gender: ____Male ___Female Marital Status: ___Single ___Married___Divorced ___Widow

Race: _____ How many children do you have? _____

Names and ages of your children:

_____

_____

_____

Name of nearest relative: _____ Phone#: _____

Your Occupation: _____ Employer: _____

Full-time: _____ Part-time: _____

Home Phone: _____ May we leave a message? Y N

Work Phone: _____ May we leave a message? Y N

Cell Phone: _____ *May we leave a message? Y N*

If client is under 18 please list parents or guardians who have legal rights to make decisions & access records.

Name : _____ *Phone:* _____

Name : _____ *Phone:* _____

Referral Information

How did you hear about us? _____

Referred by? _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Primary Care Physician Information

PCP Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

If you are filing insurance, please complete below.

Insured's Name:_____

Insured's SSN: _____ Insured's date of Birth:_____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

No need to complete the following if you have an insurance card we may photocopy.

Ins. Company Name: _____

Claims Address: _____

City, State, Zip: _____

Member ID#: _____ Policy/Group #: _____

Plan Name#: _____ Reference #: _____

Presenting Concern

Purpose of this appointment:_____

_____

_____

_____

_____

Have you ever had the same or a similar condition?____ Yes ____ No If yes, when and describe:

_____

_____

_____

_____

_____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

__ Anxiety __Eating Disorder

__ Depression __ Post Traumatic Stress Disorder

__ Anger __ Adoption Issues

__ Abandonment __ Other. List: _____

__ Alcoholism __ Other. List: _____

__ Drug Addiction __ HIV Positive

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates):

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? ____Yes ____ No

If yes, describe: _____

What medications or drugs are you taking? (List name and dosage)

_____

_____

Please list any other health problems you have, no matter how insignificant they may be:

Social History

Do you drink alcoholic beverages?__Yes ___No If so, how much per week?_____

Do you use any tobacco products?___Yes ___No Do you smoke?___Yes ____No If so, how many packs per day: _____

Do you take vitamin supplements?_____ If so, please list:_____

_____

Do you consume caffeine?_____ If so, how much per day:_____

Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

Do you sleep well at night? _____ If no, why not? _____

What are your hobbies?_____

What percentage of time during the day (at home or at your job away from home) do you spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

Family History

Your Parents:

Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased: _____

Mother: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased: _____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

FAMILY DISEASES (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety	__Eating Disorder
__ Depression	__ Post Traumatic Stress Disorder
__ Anger	__ Adoption Issues
__ Abandonment	__ Other. List: _____
__ Alcoholism	__ Other. List: _____
__ Drug Addiction	__ HIV Positive

Authorization and Release for Insurance Coverage

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Client's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Concern History

1. What is your major concern?

_____

_____

_____

_____

_____

Other concerns: _____

_____

2. If this has happened before, when was the first time you noticed this problem?_____

_____

How did it originally occur?_____

_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? _____

---

3. How frequent is the situation? Constant _____ Intermittent ____

What causes the problem to come on/get worse?

_____

_____

_____

4. Are there any other situations you would like to discuss? Yes _____ No _____ If yes, describe:

_____

_____

Are there other unrelated health problems? Yes _____ No _____ If yes, describe _____

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5. Is there anything you can do to relieve your major problem? Yes ___ No ___ If yes, describe:

_____

If no, what have you tried to do that has not helped? _____

_____

6. What makes the problem worse?_____

7. Comments:_____

_____

Please place an “X” on the line above to indicate level of problem.

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

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Counselor’s Name:_____

Counselor’s Signature:_____