



Care Counseling & Children's Services LLC
 881 3rd St. Whitehall PA 18052
 610-273-8639 E-Mail: carecounselingscs@gmail.com
www.carecounselinglv.com

CLIENT INFORMATION
 For Confidential Use Only

Chart # _____

Legal Name _____ Today's Date _____

Address _____
 Street Address Apartment #

City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____
 Leave Message? Yes No Leave Message? Yes No Leave Message? Yes No

E-Mail Address _____ Age _____

Emergency Contact _____ Phone Number _____

Occupation _____ Employer/School _____

Number of years (or highest level of) education _____ Gender _____

Relationship (or Couple) Status _____ Race/Ethnicity _____

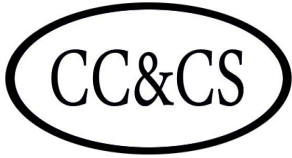
Name/Address of financially responsible party if other than client *(For minors or anyone using other 3rd party, non insurance payor)*

If client is a minor, name/address/phone of custodial parent, if different from name above _____

Medical Insurance _____ Med. Ind. ID # _____ SSN _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*)
 Clarify if client is a minor from two households *(Include any different last names.)*

| Name | Age | Gender | Relationship | Living with you? | |
|-------|-------|--------|--------------|------------------------------|-----------------------------|
| _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| _____ | _____ | _____ | _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



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Religion _____ Place of worship _____

Is it important for you to have spirituality included in your therapy? Yes No

Physician's Name _____ Phone Number _____

Date of last exam _____

Physician's Address _____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here: (Please sign a release of information with your therapist for this purpose.)

List any surgeries or illnesses you have had the past five years _____

List any medications, including the amount, that you currently take or have taken in the past 3 months _____

What is your purpose in coming to Care Counseling & Children's Services at this time? _____

Have you done previous counseling/therapy? Yes No If yes, when? _____

Name of Previous Therapist(s) _____ Purpose/issues at that time _____

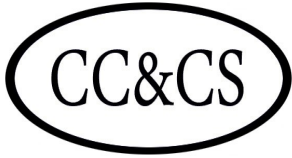
Are you a returning client? Yes No How did you learn about Care Counseling & Children's Services? _____

Did you come because you had a specific therapist in mind? Yes No If yes, name of therapist _____

Did you come because our therapist was on your insurance provider list? Yes No

Did someone refer you to Care Counseling & Children's Services? Yes No

Name of person/organization referring you _____



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Do you want to be added to our mailing list for e-newsletters and/or print newsletters? Yes No

What would you like to accomplish by coming to treatment? _____

In your own words, what do you believe is happening to you? _____

FOR THERAPIST'S USE ONLY

Therapist _____ Date _____

Payment: Insurance EAP Self-Pay Fee \$ _____

* Insurance information form must be completed, signed by client, stapled to photocopy of medical card, included with intake paperwork.

Check if insurance paperwork and/or photocopy of medical card is NOT included and will be submitted later.

File: Individual Couple Family (Number of family members _____) Group

If Couple or Family, please check one: Primary client ("patient for insurance purposes; contact for scheduling)

Additional Client (s).

 Client's Signature

 Therapist's Signature