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

CLIENT INFORMATION

Chart #_____

For Confidential Use Only

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?
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ 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