ACCESS COUNSELING PERSONAL INFORMATION FORM

Date: _____ SS/ID#: _____

Referred by: _____

(For Access Counseling use only)

PERSONAL INFORMATION

NAME: _____ AGE: _____ SEX: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____ PHONE: _____

MAILING ADDRESS: _____ PHONE: _____

EMPLOYER: _____ E-MAIL _____

For appointment reminders, urgent or emergency information may we: Call: Y / N Leave message: Y / N Email: Y / N

INSURANCE INFORMATION:

Medicaid: _____ Chips: _____ Private Ins: _____ Sliding Scale: _____

Briefly describe your reason for coming to our office: _____

_____

_____

_____

FAMILY INFORMATION

Marital Status: _____Single _____Married _____Divorced _____Widowed _____Remarried _____Other

Spouse/Significant Other NAME AGE EMPLOYER

_____

Children: _____ M F _____ M F

_____ M F _____ M F

_____ M F _____ M F

Parents/Guardians: _____

Step-Parent(s): _____

Sibling(s): _____ M F _____

_____ M F _____

_____ M F _____

Parent Address (if minor): _____ Phone: _____

Client Acknowledgement (Please sign below)

I, the undersigned, authorize the release of any medical or other information necessary to process any insurance claims to the above named insurance company. I also authorize payment to medical benefits to Access Counseling. I understand that I will be responsible for all services rendered, regardless of what my insurance pays.

I also understand that I will be charged for a missed appointment if not canceled or rescheduled 24 hours in advance.

Signature: _____ ***Date:*** _____

PLEASE CONTINUE ON THE REVERSE OF THIS PAGE

GENERAL INFORMATION

Have you received services from this office before? _____Yes _____No

If yes, give date(s) and Counselor(s)_____

Have you previously received counseling/psychological services elsewhere? ____*Yes* ____*No*

Do you have any medical problems for which you are currently being treated____ Yes If "yes", give type of treatment and name of health practitioner(s)_____

Are you taking any medications? Herb? Vitamins? _____Yes _____No If "yes", please list_____

Have you been arrested for, or convicted of a crime? _____Yes _____No If "yes", give date(s) and reason for arrest(s) and conviction(s)_____

Have you ever been abused? _____Yes _____No If, "yes", please indicate the following:

P=Physical (beating, hitting) **S**=Sexual (touching/molesting, fondling, forced intercourse

N=Neglect (failure to feed, shelter or protect you) **E**=Emotional (humiliation, degrading, etc.)

Your age Kind of Abuse By whom? Effects on you? Whom did you tell? Consequences?

_____

_____

CHECKLIST OF CONCERNS

Please check all items below that apply:

___I have no problem or concern bringing me here
___Abuse
___Aggression, violence
___Alcohol Use
___Anxiety, panic attacks
___Attention, concentration, distractibility
___Career concerns, goals and choices
___Childhood issues (your own issues)
___Children, child management, child care, parenting
___Codependence
___Confusion
___Compulsions
___Custody of children
___Dating concerns
___Death or impending death of significant person
___Delusions (false ideas)
___Dependence
___Depression, low mood, sadness, crying
___Divorce, separation
___Drug Use-RX, over the counter meds, street drugs
___Eating Problems
___Emptiness
___Financial Problems
___Grief, losses
___Irritability, anger, hostility
___Legal Matters
___Loneliness
___Marital conflict, infidelity/remarriage
___Mood swing
___Perfectionism
___Pessimism
___Relationships with family/parents/siblings
___Self –esteem/self-confidence
___Sexual concerns
___Sleep problems
___Stress management
___Suicidal thoughts
___Threats, violence
___Other_____