MaryAnn McCoy, LPCC
31720 Temecula Pkwy Suite 203
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Phone: (951) 363-5255 Fax: (951) 346-3786

FOUNDATIONS COUNSELING SERVICES

CLIENT INFORMATION

Today's Date: ____________________

Please answer the following questions as completely as possible and be advised it is protected as confidential information. Your responses will help me better understand you and your situation in order to provide the best possible services.

Name of Person completing this form: ____________________ Relationship: ____________________

Client Name: ____________________ Birth Date: ____________ Age: ____________

First Middle Last

Address: ____________________ City: ____________________

State: _______ Zip: _________ Home Phone: ____________ Cell: ____________ Work Phone: ____________

May I leave a voicemail message? ______Yes ________No May I Text you? _______Yes _______No

Email: ____________________ May I email you? ________ Yes ________ No

*Some clients prefer text and email correspondence for the convenience they afford. Please note that they are **not** considered to be confidential methods of communication and should be utilized only for administrative information related to arranging appointments. Communications will be discrete, by please indicate any restrictions: ____________________

Social Security Number: ____________________ Driver's License Number: ____________________

Gender: _____ Marital Status: ____Single ____Married ____Separated ____ Divorced _____Widowed _____Domestic Partnership

Other: ____________ Since When: ____________ Name of Partner (if applicable): ____________

Name and ages of children residing with you: ____________________

Names and ages of children not residing with you and reason: ____________________

____

Others living in the home with you: ____________________

Name of Parent(s)/Guardian(s) (if under 18)____________________

Emergency Contact: ____________________Relationship:____________Phone:____________

Address:____________________City:____________State:________Zip:_______

Employer/School:____________________Occupation:____________________

Phone:____________________Address:____________________

City:____________State:________Zip:________How Long:________Active:_____Yes________No

Highest education level achieved: ____________________ Military Service:____________________

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INSURANCE INFORMATION:

Primary Insurance Company:____________________________________Plan Name:______________________________________

Phone:__________________________________Subscriber Name:_______________________________Birth Date:_____________

Relationship:____Employer:____

Phone:_____________________________________Group Number:____

Insurance ID or Social Security #:__________________________Actively Employed:_____Yes______No; How Long:____________

COBRA:______Yes______No Term Date:___________

Secondary Insurance Policy______________________________________Plan Name:_____________________________________

Phone:_______________________________________Suscriber Name:_____________________________Birth Date:___________

Relationship:____Employer:____

Phone:____Group Number:____

Insurance ID or Social Security #___________________________Actively Employed:_______Yes______No: How Long:_________

COBRA:________Yes_______No Term Date:____________

Please describe any involvement with the legal system (arrest, convictions, probation, parole):______________________________

____

How were you referred to my practice?____

What significant life changes or stressful events have you experienced recently? ____

____

Reason for this visit:____

____

____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.) _______Yes ______No

Please provide treatment information including services, names of providers, approximate dates and outcome __________________

____

____

Have you ever been prescribed psychiatric medication?_________Yes __________No; Please specify condition, medication name, dosage, purpose, adherence and when and who prescriped:____

____

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Name of Primary Care Physician or other provider of medical care:____

Phone:_______________________Address:____

Are you currently receiving medical care and / or taking prescription medication?_______Yes_______No Please specify conditions,

Medication name, dosage, purpose, adherence, when, and who prescribed:____________________________________

____

____

Any Allergies: ______No ________Yes: ____

Are you willing to consider providing consent for communication with other providers for coordination of care?______Yes ______No

Not sure at this time and would like to discuss.

Please identify if there's a family history of any of the following. If so, indicate the family member's relationship to you:

Alcohol/substance use/other addictive behaviors:____

Anxiety/depression/panic/trauma:____

Domestic violence/child, dependent adult or elder abuse:____

Eating disorders/Obesity:____

OCD/Bipolar/Schizophrenia/ADHD or other mental illness:____

Suicide or suicide attempts:____

Other significant family history:____

Please briefly describe any issues you are experiencing or concerns you have about: Sleep:__________________________

Appetite or eating patterns:_______________________________________ Exercise:___________________________

Alcohol/substance use/other addictive behaiors____

Chronic Pain:____Relationships:_____________________________________

Grief or depression:____

Stress/anxiety/trauma/panic:____

Any other problems you are currently experiencing:____

Please indicate cultural or other identification you would like me to know about:__________________________________

If you feel that I should be aware of any special treatment considerations due to gender, age, disability, sexual orientation or cultural, religious, national, racial, ethnic identity or other reason, please explain:____

____

This is a confidential medical record. Thank you for completing it to assist me in meeting your counseling needs