



Initial Client Contact Form

Name of Client _____ Date _____

Name of Person Completing Form if different from above _____

Relationship to Client _____ Phone # if different from Client's phone _____

Client Information

Date of Birth _____ Birth Gender ____ Identified Gender ____ Pronouns _____

Race/Ethnicity _____

Primary Spoken Language _____ Other Spoken Language(s) _____

Email _____ OK to contact via email ____ YES or ____ NO

Home Phone # _____ OK to leave voicemail at home phone # ____ YES or ____ NO

Cell Phone # _____ OK to leave voicemail at cell phone # ____ YES or ____ NO

Address _____

Religious Preference: _____ Birth Place: _____

Current/Previous Therapist _____ Therapist's Phone # _____

Current/Previous Psychiatrist _____ Psychiatrist's Phone # _____

Primary Care Physician _____ PCP's Phone # _____

Do you give Pathwise Counseling consent to contact these persons to discuss your treatment? ____ YES ____ NO

(If yes, you will be asked to sign a Release of Information which gives your formal/legal written consent for contact.)

Emergency Contact _____ Phone # _____

Relationship to You _____

Do you give Pathwise Counseling consent to contact this person in the event of an emergency? ____ YES ____ NO

(If yes, you will be asked to sign a Release of Information which gives your formal/legal written consent for contact.)

Intended method of payment: Circle - Insurance Self-Pay (Cash, credit card) EAP DHS/Probation Funded

Please note that having insurance and choosing to not use it to pay for services is considered Self-Pay.

What are the problem(s) for which you are seeking behavioral health help?

1. _____

2. _____

3. _____

What do you want to accomplish in behavioral health treatment?

How did you learn about Pathwise Counseling: ____ Website ____ Psychology Today ____ Friend/Family ____ Insurance Co.

____ Another provider (please explain): _____

Client Signature _____ Date _____