Blue Q Health & Wellness

CLIENT INFORMATION

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 ______________________________ Birthdate ______________

Age______

Emergency Contact ____

Name and 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 3rd party, non-insurance payor.)*

____

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

Gross annual family income $______________ per year Number dependent on this income ________

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

Religion ______________________ Place of worship ______________________________

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

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Physician's Name ______________________ Phone ______________ 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 blue Q Health and Wellness 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 Health and Wellness ? ______________

Did you come because you had a specific therapist in mind? ☐ Yes ☐ No Name of therapist ______________

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

Did someone refer you to blue Q Health and Wellness ? ☐ Yes ☐ No

Name of person referring: ____________________

Relationship to you ____________ May we send a thank-you? ☐ Yes ☐ No *(If yes, please give us their contact information.)* First Name ________ Last Name: ________ Address (at least city & state):

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

Signature ____________________