CAROL GRIFFITH LCPC, LSW

Counseling Services

NEW PATIENT FORM

Certain information is necessary to help me focus on your concerns. In an effort to save time and energy please complete the following.
Be assured that all of your responses will be kept confidential.

PATIENT INFORMATION

Patient's last name: First:		Middle:	DOB:	Gender:
Address:		City:	State:	Zip:
Social Security no.:	Home phone no.:		Cell phone no.:	

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

Why have you come to counseling at this time?

Have you ever had counseling before? If yes, when?

What were your concerns then?

From who did you receive counseling?	Is it permissible to contact that counselor?	If yes, please fill out and sign a release of information form

HEALTH HISTORY

Have you ever experienced any of the following? Please circle all that apply

Headaches	Seizures	Diabetes
Kidney Problems	Liver problems	Unexplained fatigue
Loss of appetite	Trouble sleeping	Bladder/ Bowl problems
Visual/auditory problems		Dizziness

Surgeries, please explain why and when:			
Do you drink alcohol?	How much?	How often?	
Please list any current medications:		What is the medication for?	
Have you ever or do you now use street drugs?		What?	How often?
Have you received treatment for drug or alcohol abuse?		When?	Where?
How many hours of sleep do you average per night?			
Please list any other health concerns you may have:			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor. I understand that I am financially responsible for any balance. I also authorize Carol Griffith LCPC, LSW or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date