Amy Davenport Dakin, LCMHC, LCPC
53 Church St. #4 Kingston, NH 03848

Client Information—Adult

To help me with our first session, please fill out the following information as completely as possible:

Date: ______________________________

Name: ______________________________
First Middle Initial Last

Address: ______________________________
Street City State Zip Code

Date of Birth: ______________ Age: ______________
Place of Birth: ______________________________
Phone: (H) ______________ (W) ______________ (other) ______________
Social Security No.: ______________________________
May you be contacted at work?: ______________________________
Marital Status:
Single ________ Married ________ Separated ________ Divorced ________
If married, spouse's name: ______________________________
Age: ________ Place of employment: ______________________________
Number of years married: ______________________________
If divorced, ex-spouse's name: ______________________________
Age: ________ Number of years divorced: ______________________________
Children:
Name: ______________________ Age: ________
Name ______________________ Age: ________
Name: ______________________ Age: ________
Name ______________________ Age: ________

Employment (job title): ______________________________
Place: ______________________________

Family Physician:
Name: ______________________________
Address: ______________________________

Are you taking any prescription drugs at this time?: Yes: ________ No: ________
If yes, what type and for what purpose?: ______________________________

Referral Source: ______________________________

Insurance Information:

Company: ______________________________
Address: ______________________________
Phone: ______________________ ID No.: ______________
Group: ______________ Insured: ______________

Have you ever attempted to commit suicide? Yes ______ No ______
If yes, please describe: ______________________________
____

Have you ever had counseling before? Yes ______ No ______
If yes, please describe and list name of person(s): ______________
____

Please make note of any other comments that you feel are important to this counseling process:
____
____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize Practitioner to:

1. Furnish my insurance company with any/all information requested concerning my present claim(s).
2. Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance.

NOTICE OF INFORMATION PRACTICES

NOTICE: I keep a dated record of the services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your records to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it from my office staff. The fees for copying records, searching for records or editing records are as follows:

Copying	$.65 per page for first 30 pages $.50 for each additional page
Searching	$15.00 per search
Editing by the therapist personally when required by statute	Basic office visit charge

All copies will be released only upon receipt of payment.

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Client's Signature Date