Lighthouse Counseling Services LLC.

Personal Data Form - Adult

Date _____ Who referred you to Lighthouse Counseling Services LLC? _____

Individual Counseling

Name (First, MI, Last) _____

DOB _____ Gender (circle one) Male Female SSN _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Other _____

May we identify ourselves by using the clinic name? (circle one) Yes No

If No, how should we identify ourselves? _____

May we leave a message? (circle one) Yes No

Marital Status (circle one)

Never Married Married Separated Divorced Widowed Other

Employment Status (circle one)

Employed Student Other

Employer

Name _____ City _____

Emergency Contact

Name _____ Phone _____

Relationship _____

Treatment

To best coordinate your care, may we contact your primary physician? (circle one)

Yes No

Do you have a psychiatrist? (circle one)

Yes No

To best coordinate your care, may we contact your primary psychiatrist? (circle one)

Yes No

Have you worked or are you working with any other mental health professionals? (circle one)

Yes No

Would you like us to contact this professional regarding your counseling sessions? (circle one)

Yes No

If you answered YES to any of the above, please complete the Lighthouse Counseling Services form titled "***Release of Information Consent Form***".