Date:____________________

Primary Client Contact Information

Name: First________________ Middle__________ Last_____________________ Preferred_______

Parent/Guardian Name(s) (If applicable):____

Date of Birth: ____/____/________ Sex: M☐ F ☐ Social Security Number: _____-_____-_________

Address: ____

City: ___________________________ State: __________________________ Zip: _______________

Please check next to your preferred phone number. If applicable, please indicate if phone numbers are for primary client or parent/guardian:

☐ Cell Phone: (_____) ______-___________ Voice Message Ok☐

☐ Home Phone: (_____) ______-___________ Voice Message Ok☐

☐ Work Phone: (_____) ______-___________ Voice Message Ok☐

☐ Other Phone: (_____) ______-___________ Voice Message Ok☐

E-mail: ____

In Case of Emergency, Whom May We Contact?

Name: ____________________________________ Phone: __________________________________

Relationship to you: ____

Please Complete If Client is Under 18 Years of Age:

Mother's Name: ____ Date of Birth: _____________
Employer: ____ Primary Phone Number: ______________
Address: ____
City: ___________________________ State: __________________________ Zip: _______________

Father's Name: ____ Date of Birth: _____________
Employer: ____ Primary Phone Number: ______________
Address: ____
City: ___________________________ State: __________________________ Zip: _______________

Step-Father's Name: ____ Date of Birth: _____________
Employer: ____ Primary Phone Number: ______________

Step-Mother's Name: ____ Date of Birth: _____________
Employer: ____ Primary Phone Number: ______________

Siblings:

Name: _________________________ Age: _____ Name: _________________________ Age: _____

Name: _________________________ Age: _____ Name: _________________________ Age: _____

Background Information

Referral Information

Referred by: ___________________________ Address: ____

May we thank them for their referral: Yes ☐ No ☐

Counseling History

Are you involved in counseling now? Yes ☐ No ☐

If yes, Individual Counseling ☐ Couple's Counseling ☐ Both ☐

With whom: ____________________ Address: ____

Have you previously been counseling: Yes ☐ No ☐

If yes, Individual Counseling ☐ Couple's Counseling ☐ Both ☐

With whom: ____________________ Address: ____

Education/Employment Background

Occupation (or indicate student): ___________________________ Years of Education Completed: ____

Employer or School: _____________________________________ Highest Degree Attained: __________

Medical History

Physician and/or Medical Group: ___________________________________ Phone: _________________

Office Address: ____

Estimated date of last physical exam: __________________

Are you currently taking any medications: Yes ☐ No ☐

If yes, please list:

___________________________ mg ____ Prescribed for: __________________ By: ________________

___________________________ mg ____ Prescribed for: __________________ By: ________________

___________________________ mg ____ Prescribed for: __________________ By: ________________

___________________________ mg ____ Prescribed for: __________________ By: ________________

Are you taking any vitamins or supplements: Yes ☐ No ☐

If yes, please list: ____

Do you have any allergies: Yes ☐ No ☐

If yes, please list: ____

Do you have any significant health problems: Yes ☐ No ☐

If yes, please list: ____

Substance Use:

Number of alcoholic beverages you consume per week: ____none ____1-2 ____3-6 ____7-14 ____>14

Other mood altering substances used: __none __soda __coffee __nicotine __chew __marijuana __other

Comment: ____

Have you ever tried to cut back or quit drinking/smoking? Yes ☐ No ☐

Are you currently involved in a 12-step program? Yes ☐ No ☐ Which one? ______________

Have you previously attended a 12-step program? Yes ☐ No ☐ Which one? ______________

Comment: ____

Agreements and Policies

Please review our insurance and payment agreements as well as our office and financial policies. If you would like a copy of any of these policies, please ask the front desk staff and we will provide one for you. If you have any questions please do not hesitate to ask.

Insurance Information

Subscriber: ___________________________________ Subscriber Date of Birth: _________________

Address: ____ Phone: ____________________________

Client relationship to subscriber: ____

Insurer: ____ ID Number: ________________________

Policy Group: ______________________________________ Plan Name: _______________________

Insurance Agreement

I have read and understand the insurance policy. I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits either to myself or the party who accepts assignment below.

____________ ____________________________________ __________________________________
Date Print Client Name Signature of client, parent or guardian

Payment Agreement

I have read the financial policy. I understand and agree to comply with this financial policy. I have been given a copy of this policy. I agree to pay for all services rendered and any legal expenses incurred should this account be turned over to another party for collection.

____________ ____________________________________ __________________________________
Date Print Client Name Print name person responsible for payment

____ __________________________________
Address, City, State, Zip Signature of person responsible for payment

Office Policies

I have read the office policies and understand my rights as a client. I have been offered a copy of these office policies.

____________ ____________________________________ __________________________________
Date Print Client Name Signature of client, parent or guardian

____________ ____
Date Signature of Therapist

If client is a minor, please review and sign reverse side of this form.

CONSENT FOR TREATMENT OF MINORS

(UNDER 18 YEARS OF AGE)

____
NAME OF CLIENT

________________________________ ________________________________
NAME OF PARENT NAME OF PARENT

I am /We are the legal parent(s) of the above named client and give my/our permission to

____
COUNSELOR

to provide psychotherapy services to my/our child.

I am/We are aware that Active Change Center has no procedure for receiving after-hour emergency calls. If my/our child needs help immediately, I/We agree to contact our family physician, call 911, or go to the nearest hospital emergency room.

____ ____________
SIGNATURE OF PARENT DATE

____ ____________
SIGNATURE OF PARENT DATE

Social Interactions and Outside Activities

Describe the quality of your friendships:
__awkward __distant __suffocating __boring __ok __delightful __other (describe):________________
I have: __few friends __many friends I have: __few interests __many interests
Describe how you enjoy spending your time: ____
Do you wake up in the morning refreshed and energized? Yes No
How many hours do you sleep at night? __less than 5 hrs. __6-8 hrs. __more than 8 hrs.
Comment: ____

Family and Relationship History

Current relationship status: __single __married __partners __significant other __separated __divorced __widow/widower
Current Spouse/Partner's Name: _____________________________________ Date of Birth: _________
Current Number of Years Together: _________ How many times have you been married? ____
How many committed relationships have you had in your life? ____
First (write name) ____________________________________ How old were you? ______
Second (write name) __________________________________ How old were you? ______
Third (write name) ___________________________________ How old were you? ______
If currently divorced or single, number of years since break-up or divorce: ____
What were the reasons for your break-ups or divorces? Please include break-up/divorce dates: _______
____

If currently in a relationship: Describe the quality of your relationship with your partner:
__awkward __distant __suffocating __boring __ok __delightful __other (describe):________________
Comment: ____
Are you currently involved in an extramarital affair? Yes No
Is your partner aware of this? Yes No Have there been other extramarital affairs? Yes No
Comment: ____
Is there abuse present in any of your relationships? Yes No
Type: __physical __verbal __sexual __emotional __spiritual/religious __drugs/alcohol __other (describe)
Comment: ____
Do you have children? If so, please list names and ages:
Name: ___________________________ Age: _____ Name: ___________________________ Age: _____
Name: ___________________________ Age: _____ Name: ___________________________ Age: _____
Name: ___________________________ Age: _____ Name: ___________________________ Age: _____

Therapeutic Goals

Please describe the problem or concern for which you are seeking help:

____

____

____

When were you first aware of this problem or concern?

____

How have you tried to address this problem or concern?

____