

Valley Counseling Associates, Inc.
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CONFIDENTIAL CLIENT INFORMATION

TODAY'S DATE _____ THERAPIST TO BE SEEN _____

NAME _____ AGE _____ BIRTHDATE _____ EMAIL _____

ADDRESS _____ APT # _____ HOME PHONE _____

CITY _____ ZIP _____ WORK PHONE _____ CELL _____

EMPLOYER _____ SOC.SEC.# _____

EMPLOYER ADDRESS _____ CITY _____ ZIP _____

() SINGLE () MARRIED: HOW LONG? _____ () COUPLED, NOT MARRIED:
() SEPARATED () DIVORCED: HOW LONG? _____ HOW LONG? _____
() WIDOWED () PREVIOUS MARRIAGES: HOW MANY? _____

PARENT/SPOUSE OR PARTNER _____ AGE _____ BIRTHDATE _____ EMAIL _____

ADDRESS _____ APT # _____ HOME PHONE _____

CITY _____ ZIP _____ WORK PHONE _____ CELL _____

EMPLOYER _____ SOC.SEC. # _____

CHILDREN:

NAME _____ BIRTHDATE _____ M/F SOC. SEC.# _____

NAME _____ BIRTHDATE _____ M/F SOC. SEC.# _____

NAME _____ BIRTHDATE _____ M/F SOC. SEC.# _____

-- RESPONSIBLE PARTY IF
OTHER THAN YOURSELF _____ RELATIONSHIP TO CLIENT: _____

INSURANCE INFORMATION: (Please be sure to present insurance card to office staff) IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING COPAY AMOUNT AND AUTHORIZATION REQUIREMENTS.

PRIMARY INSURANCE:

INSURED'S NAME _____ RELATIONSHIP TO CLIENT: _____

INSURANCE COMPANY _____ POLICY/GROUP NO. _____

INSURANCE BILLING ADDRESS _____ INSURED'S I.D. NO. _____

INSURED'S BIRTH DATE _____

SECONDARY INSURANCE:

INSURED'S NAME _____ RELATIONSHIP TO CLIENT: _____

INSURANCE COMPANY _____ POLICY/GROUP NO. _____

INSURANCE BILLING ADDRESS _____ INSURED'S I.D. NO. _____

INSURED'S BIRTH DATE _____

FINANCIAL RESPONSIBILITY:

I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED IRREGARDLESS OF INSURANCE COVERAGE.

X _____
Signature of Responsible Party

PLEASE COMPLETE OTHER SIDE

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM.

PLEASE DESCRIBE THE PRESENT PROBLEM:

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?

PLEASE DESCRIBE ANY HEALTH PROBLEMS.

DO YOU SMOKE: () YES () NO

SPOUSE/PARTNER: () YES () NO

DO YOU DRINK ALCOHOL? () YES () NO

SPOUSE/PARTNER: () YES () NO

WHAT KIND/HOW MUCH/HOW OFTEN? _____

DO YOU USE ANY OTHER SUBSTANCES? () YES () NO

SPOUSE/PARTNER: () YES () NO

WHAT KIND/HOW MUCH/HOW OFTEN? _____

(i.e. MARIJUANA, COCAINE, ETC.)

ARE YOU TAKING ANY MEDICATION? () YES () NO

SPOUSE/PARTNER: () YES () NO

DESCRIBE _____ DO

YOU HAVE ANY TROUBLE SLEEPING? () YES () NO

SPOUSE/PARTNER: () YES () NO

DESCRIBE _____

RECENTLY GAINED () OR LOST () WEIGHT?

HOW MUCH/OVER HOW LONG? _____ / _____

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS?

() YES () NO

DESCRIBE _____

NAME OF PHYSICIAN _____ DATE OF LAST PHYSICAL EXAM _____

HOW DID YOU CHOOSE VALLEY COUNSELING ASSOCIATES?

() YELLOW PAGES () SAW OUR SIGN

() FRIEND () PHYSICIAN

() EAP () REFERRAL SERVICE

() REFERRED BY _____

COMMENTS:

(Rev.2011)