Juanita Mitchell, LMHC, CPT

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CLIENT INFORMATION FORM

Please Print Clearly Readmit: __Yes __No

Date_____ Client's Social Security #_____ Case #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone: (Home)_____ (Cell)_____ (Work)_____

Preferred place to contact you?_____ Is it OK to leave a message? Please circle which one(s): Home, Cell, or Work

Birthdate_____/_____/_____ Age_____ Gender __F __M School _____ Grade _____

Name of Spouse or Parent/Guardian_____Phone_____

Address_____ City_____ State_____ Zip_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Presenting Concern(s):_____

_____

_____

Emergency Information

In case of emergency, contact:

Name _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Primary Care Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Providers/Physicians_____ Phone_____

Current Medications_____

Allergies_____

Employment Information (If client is a child, use parent's employment)

Client Employer: Place_____ Phone_____

Parent/Guardian employer: Place_____ Phone_____

Spouse/Other parent employer: Place_____ Phone_____

Insurance Information

Primary Insurance_____ Contract/ID#_____

Phone_____ Group/Acct#_____

Subscriber_____ Subscriber Date of Birth_____

Subscriber Social Security Number_____ Secondary Insurance_____

Client's relationship to Subscriber __Self __Spouse __Child __Other_____

Referral Source

How did you hear of our office (or from whom)? _____

Previous Counseling ____Yes ____ No Former Counselor Name and location_____

_____