Smithson Valley Counseling Center Inc.

Confidential Patient Information

_____ SSN:_____

Client Name (First Middle Last)

_____

Address

_____ _____ _____

City State Zip Code

_(_____)_____ (_____)_____

Telephone: Cell Home

_(_____)_____ Preferred Number for Contact: Cell Home Work

Work

Is it okay to call you at home? Yes No At work? Yes No On your cell? Yes No

Okay to leave a message at home? Yes No On your cell? Yes No Okay to text a message? Yes No

Date of Birth:_____ Age_____ Place of Birth _____

Education: HS Diploma/GED Technical / Trade School AA Bachelors Masters Doctorate

Religious Background_____ Current Religion_____

Single Married Separated Divorced Widowed Other

_____ _____

Spouse (Name and Date of Birth) Occupation

Years Married:_____ Children (Names and Ages): _____

_____

Were you raised by both parents? Single parent? Relative? Other? _____

Father's Name? _____ Age_____ Occupation_____

Mother's Name? _____ Age _____ Occupation_____

Brothers and Sisters, in birth order, include yourself: _____

_____

In your family was there a history of: Alcoholism? Y N Drug Use? Y N

Prolonged physical illness? Y N Mental illness? Y N

Current Medications (name, dosage, frequency): _____

_____

Significant medical issues: _____

_____

Has there been previous psychiatric care or counseling? Y N

Has client ever been hospitalized for substance abuse, eating disorder, self harming behaviors, suicidality, other psychiatric concerns? Y N Specify reason for hospitalization or treatment _____

_____

_____

Name of Clinician / Facility Dates

_____

Name of Clinician / Facility Dates

Client's Employer Name or School _____

Employer or School Address _____

Insurance Name and Address (please provide copy of the front and back of your card and a copy of your ID card)

Who is the Policy Subscriber? Self Spouse Parent

_____

Name of Subscriber and Date of Birth if other than Client (needed for Insurance filing)

Smithson Valley Counseling Center Inc.

If Insurance is through Parent or Spouse, who are they employed by? Name/Address (needed to file Insurance):

_____

_____

Emergency Contact in Case of Medical/Psychiatric Emergency:

_____

Name Relationship Phone

Others with whom Smithson Valley Counseling Center Inc. is authorized to share my confidential information: (Family Member? Attorney? Doctor?)

_____

Name Relationship Phone

_____

Name Relationship Phone

_____

Name Relationship Phone

_____

Client's Signature Date

_____

Spouse's Signature Date

_____

Parent's Guardian's Signature Date