

Claremont Counseling and Support Center, A Psychological Corporation

Client Information

Client Name: _____ **Today's Date:** _____

Birthdate: ___/___/___ Age ___ Gender _____ SS# _____ - _____ - _____ Driver's Lic.# _____

Street Address _____ City _____

State _____ Zip Code _____ Home No. (____) _____ Ok to call/msg? Yes No

E-mail address _____ Ok to e-mail? Yes No

Employer/School _____ **Occupation** _____

Work No. (____) _____ Ok to call/msg? Yes No

Other No. (____) _____ Ok to call/msg? Yes No

Marital Status Single/Never Married Married Separated Divorced Widowed Living Together
 Other _____

How Long? _____ Spouse/Partner's Name _____

Previous Marriage? Yes No How Long? _____

Children Names/Ages _____

Emergency Contact _____ Phone No. (____) _____

Relationship to You _____ ok to call in an emergency? Yes No

Previous Counseling? Yes No Past Therapist(s) _____

How long? _____ Did you see a psychiatrist? Yes No Who? _____

Referred By _____ Phone No. (____) _____

Address _____ Ok to send thank you? Yes No

Have you or a family member been treated by anyone in our office before? Yes No

Who was treated? _____ By whom? _____

Primary Physician _____ Date last seen _____

Physician's Phone No. (____) _____ Physician's fax No. (____) _____

Release on file? Yes No Medical History _____

Current Medications and dosages: _____

Insurance Yes No Do you have a Deductible? Yes No Have you met Deductible? Yes No

Primary Insurance _____ Policy # _____

Insurance Phone No.(s) (____) _____ Group # _____

Subscriber's Name _____ SubscriberSS#/Member# _____

Secondary Insurance _____ Policy # _____

Insurance Phone No.(s) (____) _____ Group # _____

Subscriber's Name _____ SubscriberSS#/Member# _____

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Presenting Concern: Please describe your primary reason for seeking treatment at this time. _____

Was there an event which caused these problems? Yes No If Yes, Please describe _____

Please help us evaluate our services to you by rating the following:

	Excellent	Very Good	Good	Fair	Poor
Promptness of scheduling your appointment with your therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ease of getting to your therapist's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Financial Agreement and Authorization for Treatment

(Initial) _____ You have my permission to contact insurance to confirm benefits.

(Initial) _____ I give permission to my therapist to place my name on his/her mailing list so that I may be informed of upcoming events, services or resources. I understand the mailing list will not be given or sold to any other individual or agency.

(Initial) _____ You have my permission to treat me/my minor child.

(Initial) _____ I assign any insurance benefits to be paid to _____ and agree to pay any remaining balance.

(Initial) _____ I understand that my therapist may be an intern and receiving supervision from Dr. Kari Halko-Weekes (Lic#PSY 22121). I give my permission for my case to be reviewed by Dr. Halko-weekes in benefit of my treatment.

(Initial) _____ I understand that all **CANCELLATIONS** must be made 24 hours in advance otherwise a full charge will be made.

Signature _____ **Date** _____

Party to take Financial Responsibility for Counseling (If same as patient indicate "self")

Name _____ Relationship _____

Address _____ Phone No. () _____

I agree to pay all charges for the above-listed client as shown by statements, promptly upon presentment, unless credit arrangements are agreed upon in writing. I agree to pay a \$20 charge for each returned check.

Signature _____ **Date** _____