CLIENT INFORMATION

IF CLIENT IS A MINOR OR LEGAL DEPENDENT THE LEGAL GUARDIAN OR PARENT MUST ACCOMPANY THE CLIENT TO THE INITIAL APPOINTMENT. If parent or legal guardian does not accompany minor client, the appointment will be cancelled and considered a missed visit. If parents are divorced, legal documents must be presented prior to scheduling to confirm legal guardian status.

CLIENT INFORMATION		
Client Name:	Date of Birth:	Age:
Current Address:		
Email Address:		
Cell Phone:	Home Phone:	
Employer/School:	Job Title:	
Referred By:		
FAMILY INFORMATION		
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Remarried ☐ Other		
Spouse's Name:	☐ First Marriage ☐ Second Marriage	
Spouse's Address: ☐ Same as client address		
Cell Phone:	Home Phone:	
Spouse's Employer:	Job Title:	
Children (please provide names/ages):		
Nearest Relative in Case of Emergency:	Phone:	
Address:		
PARENT/ GUARDIAN INFORMATION FOR MINORS:		
Mother's Name:	Legal Guardian: ☐ Yes ☐ No	
Address: ☐ Same as client address		
Home/Cell Phone:	Work Phone:	
Father's Name:	Legal Guardian: ☐ Yes ☐ No	
Address: ☐ Same as client address		
Home/Cell Phone:	Work Phone:	
Is there or will there be any potential court involvement? ☐ Yes ☐ No		

INSURANCE INFORMATION		
Policy Holder Name:	Date of Birth:	SSN:
Relationship to Client:		

COUNSELING HISTORY	
Previous Counseling: ☐ Yes ☐ No	Clinician's Name:
Issues Addressed:	

ASSESSMENT INFORMATION			
Physical Health/ Symptoms:	☐ Headache	☐ Vomiting	☐ Diarrhea
☐ Dizziness	☐ Chest Pain	☐ Shortness of Breath	
Function/ Activity:	☐ Fatigue	☐ Little/No Sleep	☐ Weight Loss
☐ Weight Gain	☐ Academic/Work Inhibition	☐ Loss of Interest or Pleasure	☐ Excessive Worry
☐ Self-injury	Substance Use/Abuse: ☐ Alcohol ☐ Drugs ☐ Other		
Emotional Symptoms:	☐ Hopelessness	☐ Anxiety	☐ Anger
☐ Tearful	☐ Panic/Anxiety	☐ Suicidal Thoughts	☐ Indecisive
☐ Fearful	☐ Other:		

The three biggest problems in my life right now are:
1)
2)
3)

MEDICATION INFORMATION				
Medication	Strength	Taken How Often	Prescribed By	Date
Past Medications:				

COMMUNICATION PREFERENCES	
Our office will need to contact you to schedule and/or reschedule appointments, to schedule follow-up visits and other such administrative issues. To ensure that your privacy is maintained to the fullest extent possible, please select the method by which our office can contact you.	
Home Phone:	Leave Message? ☐ Yes ☐ No
Cell Phone:	Leave Message? ☐ Yes ☐ No
Work Phone:	Leave Message? ☐ Yes ☐ No

SIGNATURES

I agree and understand that my typed name below serves as my official and valid signature, and that I am the legal guardian/ parent of minor client:

Your signature and date below indicate that you have been given the opportunity to review or obtain a copy of the HIPPA Notice and that it is your responsibility to ask any questions.

*

Name Date

Your signature and date below indicate that you have read the treatment agreement and agree to abide by its terms during our professional relationship and herby give consent for myself or minor to receive treatment.

*

Name Date

My signature acknowledges that If I have had no contact for six consecutive weeks with my therapist, my case will be considered closed. However, it can be reopened at any time if I wish to continue counseling.

*

Name Date

*** PLEASE DO NOT PRINT ***

Please SAVE your completed form and click the link below to upload through our secure website: http://www.rhcounselingservices.com/forms