Summit Family Counseling, Inc.

2113 S 54th Street, Suite 5
Rogers, AR 72758
(479) 903-0070
Office@SummitFamilyNWA.com

Confidential Client Information

Please fill out, print, sign, and have this with you at your first appointment. Personal information can be too easily be compromised if submitted via an electronic means, therefore we do not recommend doing so. Please complete a form for each client.

GENERAL:

Date of 1st Appointment_________________________

General basis of being here (check one):

Individual____ Couple____ Family ____

DEMOGRAPHIC:

NAME____________________________________

ADDRESS________________________________

CITY____________________ST___ ZIP________

BIRTHDAY ___/___/___ GENDER M___ F___

OCCUPATION:

Employer / School___________________________

Occupation:________________________________

CONTACT INFORMATION:

May we message you?

Mobile #_____________________ Yes____ No____

Work # _____________________ Yes____ No____

Home # _____________________ Yes____ No____

Personal email_________________ Yes____ No____

Work email____________________ Yes____ No____

EMERGENCY CONTACT (not living with you)

Name_____________________

Mobile #___________________

Relationship________________

Your confidentiality is very important to us. We cannot guarantee your confidentiality via electronic communication (e.g., someone else might see a text message or hear a voicemail, etc.). By signing below, you indicate you understand the risks and approve of us contacting you via such indicated means.

Print Name______________________________________

Signature_______________________________________

MARITAL STATUS:

Single___ Separated___ Divorced___ Widowed___

Married_____ If yes, for how many years_________

Engaged____ If yes, how long have you dated_____

Domestic Partner_____ If yes, for how long________

Number of marriages_____

INSURANCE INFORMATION:

Subscriber's Name____________________________

Birth date ___/___/___ Subscriber's SS#___________

Address_____________________________________

City________________________ State____ Zip_____

Insurance Company____________________________

ID#____

Client is listed as: __Insured/Self __Spouse ___Child

Is spouse covered on this plan? Yes___ No____

Is client covered by Secondary Ins.? Yes___ No____

Secondary Subscriber__________________________

Birthdate ___/___/___

Address______________________________________

City _______________________ State_____ Zip______

Insurance Company______________________________

ID#____

Client is listed: ____Insured/Self ____Spouse ____Child

FOR INSURANCE CLAIMS:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Summit Family Counseling or insurance company to release any information required to process my claims.

Signature of Client_______________________________

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HOUSEHOLD:

Please list everyone in your household:

Name________________________ Relationship___________ Age___ Gender M__ F__ Currently in the home Y/N
Name________________________ Relationship___________ Age___ Gender M__ F__ Currently in the home Y/N
Name________________________ Relationship___________ Age___ Gender M__ F__ Currently in the home Y/N
Name________________________ Relationship___________ Age___ Gender M__ F__ Currently in the home Y/N
Name________________________ Relationship___________ Age___ Gender M__ F__ Currently in the home Y/N

GENERAL HEALTH INFORMATION:

Do you have any health issues you feel need to be addressed during your time here? If so, please explain:
____

List any hospitalizations or surgeries you have had in the past along with dates:
____ Date____________________
____ Date ____________________

Please list any allergies you may have____

How often do you partake of the following substances:

	Never	In the past	Currently	How Often	How much
Alcohol					
Tobacco					
Illicit Drugs					
Abuse of OTC / Rx Drug					

PHYSICIAN / SPECIALIST / PSYCHOLOGIST INFORMATION:

Physician's Name________________
Address________________________
Telephone______________________
Diagnosis treated_________________
Medication_____________________
Dosage________________________

Physician's Name________________
Address________________________
Telephone______________________
Diagnosis treated_________________
Medication_____________________
Dosage________________________

Physician's Name________________
Address________________________
Telephone______________________
Diagnosis treated_________________
Medication_____________________
Dosage________________________

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GENERAL MENTAL HEALTH INFORMATION:

Check all that apply

__ANGER / IRRITABILITY

__DECREASED / INCREASED APPETITE

__DEPRESSION / SADNESS

__DIFFICULTY CONCENTRATING

__DIFFICULTY SLEEPING

__EXCESSIVE SLEEPING

__FATIGUE

__GUILT

__HOPELESSNESS

__LOSS OF ENJOYMENT / INTERESTS

__SOCIAL WITHDRAWAL

__WEIGHT GAIN / LOSS

__ADHD

__ANXIETY

__CHEST DISCOMFORT

__COMPULSIONS

__DIFFICULTY BREATHING

__LIGHTHEADEDNESS

__NUMBNESS

__OBSESSIONS

__PANIC ATTACKS

__PHOBIAS BEHAVIOR

__RACING HEART

__RACING THOUGHTS

__ ABUSE HISTORY

  __EMOTIONAL

  __ SEXUAL

  __ PHYSICAL

__AVOIDANCE OF THOUGHTS A ASSOCIATED WITH TRAUMATIC EVENTS

__AVOIDANCE OF PEOPLE OR PLACES ASSOCIATED WITH TRAUMATIC EVENT

__INTRUSIVE THOUGHTS OR MEMORIES

__LOSS OF MEMORY ASSOCIATED WITH TRAUMATIC EVENT

__NIGHTMARES

__PTSD

__TRAUMA

__BIPOLAR

__HEARING VOICES

__HALLUCINATIONS

___IMPULSIVITY

__MOOD SWINGS

__RISKY BEHAVIOR

__CAREER / JOB ISSUES

__DIVORCE

__FINANCIAL ISSUES

__GRIEF

__LEGAL ISSUES

__LONELINESS

__MARITAL ISSUES

__PARENTING ISSUES

__RELATIONSHIP ISSUES

__SEPARATION

__SEXUAL ISSUES

What would you like to address primarily in your therapy now? ____

____

____

How have you tried to resolve or improve upon these issues thus far? ____

____

____

What are your goals for seeking therapy now? ____

____

Do you have any family history of psychological diagnosis? Yes__ No__ If yes, please explain:

____

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HOW DID YOU FIND US?

Please choose all that apply

__Phone Book: D Internet D Printed
__Yellow Pages (AT&T)
__Green (Names & Numbers)
__Red (ZipLocal)
__Internet Search
__Google Keyword Searched:_______________
__Yahoo-Keyword Searched:________________
__Other Search Engine:____________________
__Keyword Searched:______________________
__PsychologyToday.com
__Theravive.com
__FindChristianCounselor.com
__Brochure
__Advertisement

__Facebook
__Twitter
__LinkedIn
__Insurance Provider List
__Castlight (Wal-Mart)
__Business Network
__Friend - Name___________________________
__Co-worker - Name
__Family Member
__Pastor - Name
__Church_________________________________
__Judicial System
__Attorney - Name_________________________
__Other__________________________________

MISC INFORMATION

Did you consult with your insurance to learn if Summit Family Counseling is in-network with your insurance?
__Yes __No __I do not have Insurance

Did the fact that we were in or out of network with your insurance factor into your decision to choose Summit Family Counseling for counseling?
__Not at all
__Somewhat
__Major influence

Did the office staff inform you about your benefits?
__Yes __No

What was the main reason for choosing Summit Family Counseling for your counseling needs?
____
____
____

NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Print Name____________________________________

Signature_____________________________________

Date____