CONSULTANTS FOR CHANGE

733 E. Chapman Avenue
Fullerton, CA 92831
(714) 992-4656

Client Information

Client Name			Age
SSN		Date of Birth / /	
Street Address	City	State	Zip
Home phone ( )	Cell phone ( )	Work phone ( )	
Can we contact you at home? Yes _____ No _____		Can we contact you at work? Yes _____ No _____	

Occupation	Current position		
Employed by		How long?	
Work Address	City	State	Zip

Name of person financially responsible			Age
SSN			
Street Address	City	State	Zip
Home phone ( )	Work phone ( )		
Client=s relationship to responsible party:			

Briefly describe your reasons for seeking help

Who referred you to us?
Name Contact phone number ( )
What is your relationship to referral source? May we contact your referral source?
Yes _____ No _____

Primary Insurance Company Name		Phone	
Street Address	City	State	Zip
Subscriber=s name			
Address	City	State	Zip
Subscriber=s employer		Phone	
Client relationship to insured			
Group Number	Subscriber Number	Policy Number	
Deductible $_____			

Marital status (check one)
Single _____ Married_____ Divorced _____ Widowed _____ Other _____
Is this your first marriage? Yes ____ 2nd ____ 3rd ____ 4th ____ 5th ____
How old were you when you married? 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____
Duration of each marriage 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____
Current spouse=s name
Spouse=s occupation Employed by

List all people currently living in your home Name	Age	Relationship	School/Occupation

Describe any major changes in your life in the past two years

Have you ever seen a psychotherapist or counselor of any type before? Yes _____ No _____
If yes, what were the dates, reasons, and the results of your previous therapy?

Physician Name			Phone ( )
Address	City	State	Zip
Date of last physical examination			
Results			
List any health problems			
Describe your average daily intake of:			
Prescription Drugs (list names & dosage) _____			
_____			
Tobacco products _____			
Caffeine _____			
Alcohol _____			
Other Drugs _____			

Name of person to be contacted in case of emergency		Relationship	
Street Address	City	State	Zip
Home phone ( )	Work phone ( )		

Please circle all of the following areas in which you are having difficulty:

nervousness	depression	fears	anxiety
shyness	sexual problems	suicidal thoughts	panic attacks
divorce	boredom	finances	heart palpitations
drug use	alcohol use	friends	edgy
anger	self-control	unhappiness	intimacy
insomnia	stress	work	phobias
relaxation	headaches	dating skills	moodiness
legal matters	memory	assertiveness	having fun
low energy	isolation	making decisions	making friends
loneliness	self-esteem	concentration	inferiority
education	career choices	health problems	keeping a job
relationships	nightmares	marriage	irritability
children	eating problems	perfectionism	mood changes
bowel troubles	being a parent	my thoughts	family

Other:_____

Other information that you think would be useful:

I authorize my therapist to release any medical information regarding the medical, mental health, or alcohol/drug abuse history, treatment, or benefits payable, including disability or employment related information to any insurance company, the Plan Administrator, or their authorized agents that I may have coverage with, for the purpose of validating and determining benefits payable for my treatment. This includes any information/reports that may be required by any managed care contracts associated with my insurance coverage. In signing this statement, I am aware that confidentiality regarding information given to managed care/insurance companies is relinquished. My confidentiality in this regard is protected only by the laws and ethics governing the managed care and insurance companies.

_____ _____

Date Client signature (parent if client is a minor)