Compassion Counseling Services, PC

Client Information

Client's Name: ______________________________ DOB______________________

Client's Address: ____

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Client's phone numbers:

Home: ____

Cell: ____

Work: ____

Indicate your preferred way of being contacted by Compassion Counseling Services with a *

Email: ____

Legal Guardian (if applicable): ______________________Phone #____________________

Person Financially Responsible: ______________________ Phone #____________________

Primary Care Physician______________________________ Phone #____________________

Psychiatrist (if applicable)__________________________ Phone #____________________

Emergency Contact: ______________________________Phone #____________________

Referred by: ____

Primary Policy Holder Information

Name:____

Address(if different from Client): ____

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Employer: ____

Primary Insurance Company: ____

Subscriber ID#______________________________ Co-pay Amount:____________

Auth #______________________ Dedectible met? ____yes ____no

Signature____ Date____________________

OFFICE USE ONLY

Dx: ______________________________*Date:* ______________*Therapist:* ______________

Additional Information

Name____ Date_______________

How did you hear about us? ____

Reason(s) for seeking therapy:____

____

____

Has client seen another therapist in the past year? _____no _____yes # of times_________

List any medication that you are currently taking____

____

Allergies____

Health Concerns____

____

Family members (or others residing in the client's home):

Name____Relationship________________Age____

Name____Relationship________________Age____

Name____Relationship________________Age____

Name____Relationship________________Age____

Name____Relationship________________Age____

Place of Employment____

Your Education Level ____

Hobbies/Activites____

Other information or concerns you would like your therapist to be aware of?

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