

#5 Executive Woods Ct., Lower Level
Swansea, Illinois 62226

Client Information Form 1

Today's date: _____

Identification

Your name: _____ DOB _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Can we leave a message at this number? YES NO

Cell Phone: _____ Can we leave a message at this number? YES NO

Do you agree to text reminder of appointments at cell number? YES NO

If YES then who is your cell phone company: (Verizon, AT&T, T-Mobile, etc.): _____

Do you agree to reminders/messages on your email? YES NO

Email address: _____

Name of Employer: _____ Occupation: _____

Address: _____

Street Suite# City State Zip

Work phone: _____ Can we leave a message at this number? YES NO

Spouse: _____ Emergency Contact: _____ / _____

Address if different than above: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Can we leave a message at this number? YES NO

Spouse's Employer: _____ Work Phone: _____

Payment Information

Responsible Party: _____ Relationship to the Client: _____

Address if different than above: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Insurance Information

Insurance Company Subscriber No. Policy No.

Primary Policy Holder Name Social Security Number Date of Birth

Billing Address Phone Contact

Secondary Insurance Company Subscriber No. Policy No.

Billing Address Phone Contact

Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? • Yes • No

How did this person explain how I might be of help to you? _____

Client Signature

Date

W

Belleville Counseling Associates
#5 Executive Woods Ct., Lower Level
Swansea, Illinois 62226

Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. History

1. Please list any illnesses that may be interfering with your current functioning. Be sure to include any head trauma, history of seizures, and significant adult or childhood illnesses.

Age	Illness/diagnosis	Treatment received	Treated by	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. What are your primary reasons for seeking counseling? _____

**Primary Care Physician
(Name, address & Phone)**

Please check the appropriate box below:

May I have your permission to inform him/her of your involvement in counseling? • Yes • No

May I have your permission to discuss with your physician any treatment concerns, evaluations, needs and/or progress? • Yes • No

Client Signature

Date