



CLIENT INFORMATION FORM

CURRENT DATE:	REFERRED BY:			
NAME:	PREFERRED NAME:			
DOD	105	0 : 10 #		
DOB	AGE	Social Sec #		
ADDRESS:	(CITY:ZIP:		
CELL PHONE:		WORK PHONE:		
E-MAIL:	RE	LIGION:		
EMPLOYEE OR SCHOOL NAME:_		POSITION:		
PHYSICIAN:	PHONE:			
PSYCHIATRIST:	PHONE:			
Mental Health MEDICATION:				
EMERGENCY CONTACT		PHONE #		
INSURANCE CO:	INSUR	ED'S ID NUMBER:		
INSURANCE PHONE (for MH/Med	dical on back of card):	GROUP #:		
If covered under spouse/parent' PRIMARY COVERAGE'S NAME/ADDRESS:				
INSURED'S DOB:	INSURED'	S SOCIAL SEC #		
INSURED'S EMPLOYER:				
insurance company be made dire	ectly to Angie L. Heath, LCSV ent of benefits either to myse	to process this claim. I request the payment from my W with Clinical Conversations, Inc or (if utilizing out of elf or to the party who accepts assignment below).		
Signature:	, or Legal Guardian	Date:		
Patient, Parent,	, or Legai Guardian			



APPOINTMENT REMINDERS

Shall we input the cell phone # from above or would you like reminders sent to another number? CADULT) INTAKE QUESTIONAIRE	You can receive an appointment reminder via text. This service is from Jituzu.com which is HIPAA compliant and is no charge to you. We input the minimal information (your name) into their system along with your phone number. Would you like to receive appointment reminders?					
Comments: Date:	Yes	No.	o. I'll remember my appointments on my own.			
Name:	Shall we input the cell phone # from above or would you like reminders sent to another number?					
1. How many days have you been unexpectedly absent or tardy from work/school in the last 30 days? 2. Do you have any current or history of medical conditions/illnesses? Solution of the last 2 years? 4. Have you moved in the last 2 years? 5. Have you changed jobs in the last 2 years? 6. Have you experienced a recent death of someone close? 7. Have you or others been concerned about your alcohol or drug use? YES NO 8. Do you starve yourself, or make yourself throw up? 9. Are you very concerned about your weight? 10. Do you self-injure? 11. Do you have any suicide thoughts or past attempts? 12. Do you have any sticide thoughts or past attempts? 13. Do you feel you are in danger of being hurt? 14. Do you have extreme irritability or outbursts of anger? 15. Do you have problems in your relationships with other people? 16. Do you have extreme irritability or outbursts of anger? 17. Do you have sexual concerns? 18. Do you have sexual concerns? 18. Do you have going to work? 19. Are you experiencing financial problems? 19. Are you experiencing financial problems? 10. Do you have exessive fears, worries, or nervousness? 11. Do you have exessive fears, worries, or nervousness? 12. Do you have exessive fears, worries, or nervousness? 15. Do you prefer not to participate in community or social activities? 16. Do you prefer not to participate in community or social activities? 17. Expendit the last 2 years? 18. Do you prefer not to participate in community or social activities? 18. Do you prefer not to participate in community or social activities? 19. Have you lost hope that your problem can be resolved? 10. Do you prefer not to participate in community or social activities? 11. Do you problem that your problem can be resolved? 12. Do you prefer not to participate in community or social activities? 15. Do you have expendent the last 2 years? 16. Do you problems? 17. Do you problems? 18. Do you prefer not to participate in community or social activities? 19. Have you lost hope that your	(ADULT) INTAKE QUESTIONAIRE					
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Other issues needing to be discussed: