Client Demographic Form

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Please provide the following information and answer the questions below. Please note: Information you provide her is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____ _____ _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if Under 18 years):

Name: _____ _____ _____
(Last) (First) (Middle Initial)

Address: _____

City: _____, State: _____ Zip Code: _____

Home Phone: _____ May we leave a message? Yes NO

Work Phone: _____ May we leave a message? Yes NO

Cell: _____ May we leave a message/text? Yes NO

E-Mail: _____ May we leave a message? Yes NO

Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____/_____/_____ Age: _____ Gender: ( ) Male ( ) Female

Marital Status: Single/Married/Widowed/Divorced Occupation: _____

Please List any Children/Age:

_____
_____
_____
_____

Referred by (if any) _____

POLICY ON BILLING

*Appointments must be canceled 24 hours in advance or client may be charged for full session. When you make an appointment, time is reserved for you. Please provide 24-hour notice for cancellation and/or rescheduling of an appointment. Please make every effort to keep and be on time for scheduled appointments. As a professional, I will give you the same respect.

If there is a financial need, a sliding fee will be considered when setting fees after the initial session.

Will you be paying for our services yourself? _____ if not, please identify who or what company/agency will be paying for the services: _____

For your convenience, I allow recurring payment authorization:

I _____, authorize Janet Adams MS, LMFT, LPC, to debit my credit card for recurring payments for counseling services. I understand this information will be used to remit payment to Janet Adams MS, LMFT, LPC for services rendered and outstanding balances.

Visa/MasterCard/AMEX (circle one)

_____ _____ _____
Card number Exp. Date Security Code

_____ _____
Printed name on card Signature

*You are not required to fill out your credit card information.

Medical History

Have you previously receive any type of mental health services (psychotherapy, psychiatric service, etc.)? _____Yes _____No

Previous Therapist/Practitioner: _____

Current Prescription medication: (List All)

_____

_____

_____

List any chronic health conditions: _____

Emergency Contact

Name:_____ Relationship:_____

Address: _____

Phone: _____

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes please indicate the family member's relationship to you in the space provided.

Alcohol/Substance Abuse	Yes No	_____
Anxiety	Yes No	_____
Depression	Yes No	_____
Eating Disorders	Yes No	_____
Obesity	Yes No	_____
Obsessive Compulsive Behavior	Yes No	_____
Schizophrenia	Yes No	_____
Suicide Attempts	Yes No	_____

Have you ever attempted to commit suicide Yes No

Client Signature: _____ Date: ____/____/_____

Therapist Signature: _____ Date: ____/____/_____