



Client Information Form

Please provide the information requested below in as much detail as possible. Couples and families should provide the requested information for each person. If you need more space, please use the back of the form and note on the face of the form that there is more information given on the back. Thank you for your assistance.

Full Name (Including those who live in your household)	Sex	Relation	Date of Birth
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Address(es):

Street:	City:	State:	Zip:
Street:	City:	State:	Zip:
Street:	City:	State:	Zip:
Street:	City:	State:	Zip:

Social Security Number: - -

Home Phone(s):

Work Phone(s):

Employer:

Position:

Services you are requesting (individual, couple, marriage, or family counseling, on-going psychotherapy, short-term supportive counseling, evaluation and referral, etc.)

Have you ever been to a counselor, therapist or psychiatrist? If so, please describe briefly your experience. Was it helpful?

Have you ever been the victim of violent or sexual abuse? If yes, please explain:

Briefly describe the amount of alcohol you consume per month:

Briefly describe your sleep patterns, especially any difficulties or changes:

Is there any other information you feel a therapist should know? If yes, please explain:

Marital History:

Prescription Medications:

Drug or Alcohol History (personal, family, or direct family):

Describe whether or not you have experienced the following in the last five years: Serious illness, hospitalization, change of employment status or change of job, death of a close relative, divorce or separation, birth of a child, or any other significant life experience:

Describe briefly the problem(s) you wish to present or the reasons why you are requesting counseling or psychotherapeutic services:

Payment Information *Payment for professional services is due at the time services are rendered:*

Type of Payment:

Insurance reimbursements are made directly to the client. A form describing the professional services provided is given to each client upon request.

Insurance Company and Address:

Company Name:

Address:

Employer/Plan Name:

Plan Identification Number:

Participant Name and Number:

Relation to Plan Participant:

With my signature, I understand that it is my responsibility for payment to be made directly at the time that services are rendered, and that the Genesis Counseling Center will file my insurance information so that I may directly receive reimbursement, unless otherwise specified and negotiated. I also understand that it is my responsibility to make arrangements in the event of a cancellation, to notify the Genesis Counseling Center 24 hours in advance of a cancellation, or that I will be responsible for making full payment in the event I miss an appointment.

Your Signature(s):

Date: