DEMOGRAPHIC FORM - ADULT

Personal Information:
Name: ____
Preferred name: ____________________ Gender identity: ____________
Date of Birth: ______________ Age: ________ SS# ______________
Address: ____
City: ________________ State:__________ Zip code: __________
Email address: ____
Phone number: ________________ Alternate phone: ________________
Referral source: ____

Where would you like to be seen?
Lacey clinic: ________ Longview clinic: ________ Telehealth virtual clinic: ___________
If you would like to be seen via our Telehealth clinic, what *originating site* will you connect from?
(such as a clinic, St. Pete's Hospital, home, etc.) ______________________________

Relationship Status:
Single: _____ Partnered: _____ Divorced: _____ Married: _____ Other: _____

Spouse or Significant other Name:____________________ Age: _____
Phone Number: ________________ Email: ________________
Any children: Yes____ No: _______
Name: ________________ Name: ________________

Your Occupation:
Client: ____
Your significant other's occupation: ______________________________

Education:
Grades completed: ________________ Degree(s): ________________
Spouse/significant other's educational attainment: ______________________

Previous mental health services:
Have you been in counseling/therapy before? ______Yes _______ No:
If yes, with whom? (Name of previous counselor/therapist) ______________________
Address: ____
Telephone number: ________________ Fax number: ________________
Email address: ________________ Website: ________________

Outcome of counseling or therapy with previous provider/s:
____
____
____
____

Medical History:
Primary care physician/clinic: ____
Address: ____
Telephone Number: _______________________ Fax number: _____________________________

Current medications (prescribed and over-the-counter)
____
____
____

Any past mental health hospitalizations? _____ Yes _____ No
If yes: Name of facility: ____

Alcohol and drug history (past & present):
____
____
____
____

Reason(s) for seeking counseling or therapy:
____
____
____
____
____
____

Financial Policy:

Payment is due at the time of service. A 48-hour notice is required for cancellations; please see our Informed Consent for no-show and last-minute cancelation penalties. If your insurance denies our claim, you will responsible for the full amount.

Signature: __________________________________ Date: ________________________________

Signature: __________________________________ Date: ________________________________