DEMOGRAPHIC FORM

I. Personal Information

Name: ____
Date of Birth:___________________________Age:__________**SSN #** - -
Address: ____
City:_____________________________Zip Code: _________________________

Telephone Number: Home: ( ) _________________ Cell: ( ) _____________
Your Email: ____

Referral Source: ____

Spouse/significant other Name:_______________________________________Age: _____
Phone Number: ____________________ Email: _________________________________
Any child or children: Yes____ No: ______
Name: ____
Name: ____

Relationship Status:
Single:_____Partnered:________Married: _______ Divorced:______Other: ___________
Your Occupation:
Client: ____
Your significant other's Occupation: ____

Education:
Grades Completed: ____
Degree(s): ____
Your Spouse/significant other's Educational attainment: ___________________________

Insurance Information:
Insurance Name: _________________________________ Subscriber # ________________
Group Number__________________ **Guarantor:** _____________________________________
Primary Insured name: _________________________Primary Insured DOB: ___________
Mental Health Contact Number:___________________Effective Date: ___________________

II. Counseling/Therapy

Have you been in counseling/therapy before? Yes:_______No: _______
If yes, with whom? ____
Name of previous counselor/therapist
Address: ____
Telephone Number: ____

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

III. Medical History

Primary Care Physician: ____
Address: ____
Telephone Number: ____

Current medications (prescribed and over the counter)

____
____
____

Any mental health hospitalization? Yes: _____ No: ____
Name of Hospital: ____

Alcohol and Drugs (Past & Present):

____
____
____

Reason(s) for seeking counseling/therapy:

____
____
____
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____

IV. Financial Policy

Payment is due at the beginning of each session. A *48-hour notice is required* for cancellations. Except for unforeseen circumstances, such as emergencies, otherwise you will be charged full fee for appointment missed. ***If your insurance denied our claim you are responsible for the full amount of the counseling fees.***

Signature:______________________________ Date: __________________

Signature:______________________________ Date: __________________