Wings of Eagles Counseling Clinic

To nurture a partnership of hope, health and wholeness in all people using solution focused and evidenced bases practices

CLIENT INFORMATION

For Confidential Use Only

Legal Name_____ Today's Date _____

Address_____
Street Address Apartment #

_____
City State Zip Code

Home Phone_____ Work Phone _____ Cell Phone _____
Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

E-Mail Address_____ Birthdate_____ Age_____

Emergency Contact _____
Name and phone number

Occupation_____ Employer/School_____

Number of years (or highest level of) education _____

Gender _____ Relationship (or Couple) Status _____ Race/Ethnicity_____

Name/Address of financially responsible party if other than client *(For minors or anyone using 3rd party, non-insurance payor.)*

If client is a minor, name/address/phone of custodial parent, if different from name above_____

_____

Gross annual family income $_____ per year Number dependent on this income _____

Family and household members (includes housemates, spouse, partner and all children *(Continue on back if needed.)*
Clarify if client is a minor from two households *(Include any different last names.)*

Name	Age	Gender	Relationship	Living with you?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Religion _____ Place of worship_____

Is it important for you to have spirituality included in your therapy? ☐ Yes ☐ No

PLEASE CONTINUE ON PAGE 2

CLIENT INFORMATION

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Chart #_____

Physician's Name _____ Phone _____ Date of last exam _____

Physician's Address _____

It is our practice to coordinate care with the client's physician when this would be helpful. If you agree that we may contact your physician, please check here: ☐ *(Please sign a release of information with your therapist for this purpose.)*

List any surgeries or illnesses you have had the past five years _____

_____

List any medications, including the amount, that you currently take or have taken in the past 3 months _____

_____

_____

What is your purpose in coming _____

_____

Have you done previous counseling/therapy? ☒ Yes ☐ No If yes, when? _____

Name of Previous Therapist(s) _____ Purpose/issues at that time select one

_____

Are you a returning client? ☐ Yes ☐ No _____

Did you come because you had a specific therapist in mind? ☐ Yes ☐ No Name of therapist _____

Did you come because our therapist was on your insurance provider list? ☐ Yes ☐ No

Did someone refer you ○ Yes ◙ No Name of person referring: _____

Relationship to you _____ May we send a thank-you? ☐ Yes ☐ No *(If yes, please give us their contact information.)* First Name _____ Last Name: _____ Address (at least city & state):

_____

Do you want to be added to our mailing list for e-newsletters and/or print newsletters? ☐ Yes ☐ No

FOR THERAPIST'S USE

Therapist:_____ **Office:**_____ **Fee (90791):** _____ **Fee (90834/47):** _____ **Date:** _____

Payment: ☐ Ins* ☐ EAP ☐ 3rd Party Non-insurance Guarantor (i.e.. church) ☐ Self-pay

* Insurance Information form must be completed. double-signed by client. stapled to photocopy of medical card. included with intake paperwork.
☐ Check if insurance paperwork and/or photocopy of medical card is not included and will be submitted later.

File: ☐ Individual ☐ Couple ☐ Family (Number of family members _____) ☐ Group

If Couple or Family. check one: ☐ **Primary client** ('patient' for insurance purposes: contact for scheduling) ☐ **Additional client(s)**