

# Counseling & Psychology Resources

A CENTER FOR COUNSELING AND PSYCHOLOGICAL HEALTH CARE

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## CLIENT INFORMATION QUESTIONNAIRE

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully or ask for assistance if you do not understand an item.

Full name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Employer: \_\_\_\_\_ SSN: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Briefly describe your reason for seeking assistance:

Who suggested you contact our office?

Who is your primary health care provider (physician)?

List any major health problems for which you are being treated:

List any medications you are now taking:

Have you ever received psychiatric, psychological, or counseling services?  
If yes, explain:

List members of your family or others in your home:

Name	Age	Relationship	Occupation
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In the event of an emergency, please call: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Agreement for Counseling or Psychological Services**

I, \_\_\_\_\_, the client, agree to keep all scheduled appointments and understand that 24-hour notice is required for cancellation. I agree to pay for appointments that are not cancelled within 24 hours unless a legitimate emergency occurs. I understand and accept that I am fully responsible for all charges and that all fees or co-pays are due at the time the service is provided unless other arrangements have been made. *Please remember, in most cases, your insurance carrier has an agreement with you, not our office, to assist with payment of your health care costs. We strongly encourage you to contact your carrier directly concerning your outpatient mental health or other health care benefits.*

I understand that necessary information will be provided to my insurance carrier, in order to process any claim made for services.

My signature below means that I understand and agree with all points above.

\_\_\_\_\_  
Signature of Client Date

**Referral Release Form**

Our office would like to extend our appreciation and communicate with your physician or other professional that referred you to our office. Your signature below authorizes us to do so.

Name of Referring Professional (e.g. Physician or Attorney): \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Client: \_\_\_\_\_

Date: \_\_\_\_\_