Donald Cronk, LMHC, CST
Client Information Form

Today's Date:_____

Client Name:_____ Age:_____ DOB:_____

Client Name:_____ Age:_____ DOB:_____

Address:_____
Street City Zip Code

Home Phone:_____ Cell Phone:_____

Do I have your permission to text you messages related to appointment dates and times? Y N

Emergency Contact Name/Telephone:_____

E-mail Address:_____

Briefly describe the reason you are seeking treatment today

_____

_____

_____

Have you had suicidal thoughts?_____

INSURANCE INFORMATION

Insurance Carrier:_____

Name of Insured:_____ DOB:_____

Insured's Employer:_____ Occupation:_____

MEDICAL INFORMATION

Family Physician:_____ Phone:_____

Other Provider(s) You See:_____

Current Medications:

Name:_____Dosage:_____Date Prescribed:_____

Name:_____Dosage:_____Date Prescribed:_____

Name:_____Dosage:_____Date Prescribed:_____

Name:_____Dosage:_____Date Prescribed:_____

Client:_____

Over the Counter Medications/Supplements/Herbal remedies You Take: (Please indicate dosage/frequency)

_____
_____

Current use of Marijuana/Cocaine/Methamphetamine or other drugs not prescribed to you? History of use?

_____

On average, how many alcoholic beverages do you consume in a week?_____

Please list the names, ages and relationship (to you) of others living in your home:

_____
_____
_____

What do you eat?

_____
_____

Do you exercise?_____

Please check the boxes below if you have problems with:

	Getting to Sleep		Appetite		Isolation
	Staying Asleep		Finances		Self Esteem
	Feeling Stressed		Worry/Anxiety		Job/Work
	Sexual Functioning		Friendships		Anger
	Partner/Marital		Diet		Frustration
	Family		Loss		Fear
	History of Abuse		Sadness		Communication
	Body Pain		Happiness		Addiction

My signature below signifies that I understand that sessions that extend beyond 53 minutes will be subject to an additional charge for which I am responsible to pay. In addition, I understand that I will be responsible to pay the full session fee ($160.00) for appointments cancelled without 48 hours notice.

_____ _____

Client Signature Date of Signature