Caines Center For Psychotherapy

Claire Caines, MSW, LCSW, CADC

Client Information Form

Please Complete, Print and Bring This Document to Your First Visit

Today's date: ____________________________

A. Identification

Your name: ____ Date of birth: _____________ Age: ________

Nickname: ____ Social Security #: ______________________

Address: ____ Apt.:_______________

City: ____ State: ______________ Zip: ____________________

Home/Cell: ____

Email: ____

Marital status: ______ Spouse's name: ____ Age: _______

Spouse's Occupation: ___________________________________

Who do you live with: ____

B. Referral: Who gave you my name?

Name: ____

C. Financial Information:

Name of Insurance Company: ____

Address: ____

City: ____ State: ______________ Zip: ____________________

Phone: _______________________________

Name of Insured: _______________________________ DOB: ___________ SS#: ______________________

Insured's Address: ____

City: ____ State: ______________ Zip: ____________________

Insured's Employer: ____

ID #: _____________________________________

Co-Pay: $ _______________ Deductible: $ _______________ Number of Sessions: _____________________

Authorization if applicable: ______________________________

Self-pay fee if applicable: $ _______________

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D. Medical Information

Primary Care Doctor: ____ Phone: ______________________

Medical Conditions:

Are you taking any medications for these conditions? Yes No

Have you ever received psychological counseling services before? Yes No

When?	From Whom?	For What?	With What Results?

Have you ever taken anti-depressant or anti-anxiety medications? Yes No If yes, please indicate:

When?	From Whom?	Which Medication / For What?	With What Results?

Do I have your permission to speak with your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

E. Your current employer

Employer: ____

Address: ____

Your Position: ____

How long on this Job? _____________

How do you like your job? ____

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F. Are you a student? Yes No

School: ______________________________ Major: ________________________ Graduation date: ________

G. Marital/Relationship History

	Spouse's Name	How long?	If divorced, when?	Reason for divorce
First	____________________	________	__________	____
Second	____________________	________	__________	____
Third	____________________	________	__________	____

H. Significant Relationships

	Significant other's name	How long?	If ended, when?	Reason for ending
First	____________________	________	__________	____
Second	____________________	________	__________	____
Third	____________________	________	__________	____

I. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Age	Sex	Grade	P
_________________________	____	____	____	
_________________________	____	____	____	
_________________________	____	____	____	
_________________________	____	____	____	
_________________________	____	____	____	

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J. Please tell me the main issue that brought you to see me?

K. What would you like to accomplish in therapy?

L. Is there anything else you would like me to know about you?

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