

CROSSROADS AFFORDABLE COUNSELING OF NORTH TEXAS
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Adult Client Information Form

Today's date: _____ **Client #** _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ May we contact you at this number? YES NO

Cell phone number _____ May we contact you at this number? YES NO

E-mail address: _____

May we contact you at this e-mail address? YES NO

B. Referral: Who referred you to my office?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No

How did this person explain how I might be of help to you? _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for therapy, may I tell your medical doctor so that he/she can be fully informed and we can coordinate your treatment? Yes No

In the event of an emergency, may I contact your medical doctor and disclose necessary information so that he/she can be fully informed and we can coordinate your treatment? Yes No

D. Your current employer

Employer: _____ ++ _____ Address: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

E. Marital History

Are you: Single _____ Married _____ Divorced _____ Widowed _____ Never Married _____

If you are married, how long have you been married? _____

If you are divorced, give the month and year that your divorce was granted _____

If you are remarried following divorce/death of spouse, give the date of the marriage _____

Are you currently separated from your spouse? Yes No

Are you contemplating separation or divorce? Yes No

Do you have children? Yes No

If so, please list their names and ages: _____

F. Family Members (list those living in home with you):

Name	Age	Sex	Grade	Relationship to You

G. Medications:

Name of Medication?	Dosage/Mg?	Frequency?

H. Any problems or concerns about your medications? _____ Yes _____ No
(If yes have you talked to the prescribing physician? _____)

I. Emergency Contacts

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency. Please be aware that the persons listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about you in the event of an emergency.

J. Chief Concern(s): Please describe the main difficulty that has brought you to see me: _____

K. Have you ever received counseling services before? __No __Yes. If yes,

When?	With Whom?	For What?	With What results?

L. Abuse History? _____I was not abused in any way. _____I was abused (sexual, physical, emotional, neglect) If you were abused:

Age of Abuse	Who did it?	Whom did you tell?	Consequences of telling?

M. Health

List all illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other relevant medical conditions.

Condition	Age	Treated by whom?	Consequences?

N. Residences Outside your home? (Examples would be Foster Care, Residential Placement, etc) ____ **No** ____ **Yes** (If yes please complete below):

From	To	Location	Reason for moving	With whom	Any problems?

O. Education

Schools attended (Name and location)	Degree/Level Completed	Date Completed

(Office Use Only) Insurance Information:

Name of Insurance Company: _____ Effective date of coverage: _____
Policy ID #: _____ Group #: _____ SSN#: _____
Policy Holder Name: _____ Date of Birth of Policy Holder _____
Policy Holder Employer: _____ Phone Number: _____
Authorization/Certificate # _____ Beg and End Dates: _____
Of Authorized Visits: _____ **Benefits:** Deductible: _____ Co Pay: _____ #Visits per year: _____