

JAMES FAUST & ASSOCIATES • PLLC

Client Information (please print)

Name _____
(First) (M.I.) (Last)

Address _____

City _____ State _____ Zip+4 _____ - _____

Date of Birth _____ Social Security _____ - _____ - _____

Home Phone _____ Work Phone _____, Ext _____

Cell Phone _____ Message Phone _____

May we leave a message? Home Work Cell Message

E-mail Address _____

Marital Status Single Married Separated Divorced

Employer/School _____

Employer Address _____

Occupation _____

Education-Highest Grade Completed _____ College Yes No

Race _____ Sex Male Female

Religion _____ Residence Urban Rural

Next of Kin _____ Phone _____

Address _____

Emergency Contact _____ Relationship _____

Phone _____

Children Living at Home (Name/Age) _____ / _____

_____ / _____ / _____

Client History

Have you ever been diagnosed with a psychiatric illness? Yes No

If "Yes" please describe _____

Where _____ When _____

Doctor / Agency _____

Have you ever been hospitalized for a psychiatric condition? Yes No

If "Yes" where and when?

Hospital	Reason	Date
_____	_____	_____
_____	_____	_____

Have you ever attempted suicide? Yes No

If "Yes" please describe circumstances including where and when _____

Do you have any other health problems? Yes No

If "Yes" please describe _____

Please describe any psychotropic medications you are taking?

Medication	Dosage
_____	_____
_____	_____
_____	_____

Your Doctor (Name) _____ Telephone _____

Address _____

Please check any that apply:

Individual

- Depressed mood
- Anxiety
- Irritable
- Panic attacks
- Change in sleep
- Feelings of hopelessness
- Change in appetite
- Change in energy
- Mood swings
- Anger
- Poor academic performance
- Poor work performance
- Suicidal thoughts or ideas

Relationship / Social

- Conflict with family members
- Conflict with friends
- Conflict with employer, co-workers
- Relationship dissatisfaction
- Inability to form or maintain friendships
- Relationship violence

Please list any other information you would like me to know

Client Signature _____ **Date** _____

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Please complete this page if you are using your insurance to pay for counseling.

Primary Insurance	Secondary Insurance
Name of Ins. Co.:	Name of Ins. Co.:
Insurance Phone #	Insurance Phone #
Insured's Name (on card):	Insured's Name (on card):
Insured's ID No.:	Insured's ID No.:
Insured's DOB:	Insured's DOB:
Group or Policy No:	Group or Policy No:
Plan or Program Name:	Plan or Program Name:
Insurance Billing Address:	Insurance Billing Address:
Effective Date:	Effective Date:
Deductible:	Deductible:
Insurance Coverage:	Insurance Coverage:
Co-Pay or Co-Ins.:	Co-Pay or Co-Ins.:
Allowed # of Visits:	Allowed # of Visits:
Date verified / Name of Person:	Date verified / Name of Person:
Referral Required?	Referral Required?
Phone # for referral:	Phone # for referral:

By my signature below I accept assignment of insurance payments for services rendered.

Client Signature _____ **Date** _____