# East Cascade Counseling Services LLC

## Client Information Form

Today's Date: ____________________________ Email: __________________________________________________

A. **Identification**

Client Name: ______________________________________ Date of Birth: _________________ Age: _________
Home Address: ________________________________________ City: _____________ Sate: _______ Zip: ________
Home Phone: ___________________________________ Cell Phone: ________________________________________
If client is a minor, Parent/Guardian: __________________________________________________________________

B. **Referral: Who gave you my name?**

Name: _________________________________________________________ Phone: ___________________________
Address: ___________________________________________________________________________________________
May I have your permission to thank this person for the referral? Yes☐ No☐

C. **Medical Care: From whom or where do you get your medical care?**

Doctor's name: ____________________________________________________ Phone: _________________________
Address: ___________________________________________________________________________________________
Date of last physical (estimated): ________________ Reason for visit: ____________________________________
Any medical conditions that you would like us to be aware of: ____________________________________________
If you enter treatment with East Cascade Counseling Services, may we have your permission to consult with your medical doctor so that he/she can be fully informed and we can coordinate your treatment? Yes☐ No☐

D. **Emergency Contact Information**

Name: _________________________________ Phone: _____________________ Relationship: _________________
Address: ___________________________________________________________________________________________

E. **Current Employment** or ☐ Not currently employed

Employer: ____________________________________ Address: ___________________________________________

F. **Insurance**

Primary Insurance: ___________________________________ Phone: _______________________________________
Address: ___________________________________________________________________________________________
Policy #: _____________________________________ Group #:__________________________________________
Policy Holder's Name: ________________________ Date of Birth: ______________ Social Security: _____________

Secondary Insurance: ___________________________________ Phone: _____________________________________
Address: ___________________________________________________________________________________________
Policy #: _____________________________________ Group #:__________________________________________
Policy Holder's Name: ________________________ Date of Birth: ______________ Social Security: _____________

G. **Other helpful information**

Previous counseling, psychological services, alcohol/drug treatment? Yes☐ No☐ If yes, when and for what reason: ____________________________________________________________________________________________
How was your previous counseling experience? ______________________________________________________
Brief description of your reason for today's visit: ___________________________________________________
___________________________________________________________________________________________________

I authorize payment of mental health benefits to East Cascade Counseling Services. I also authorize the release of any mental health information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

___________________________________________________________________________________________________
Client/Guardian Signature: Date: