Segues Christian Counseling LLC
Client Intake and Billing Information

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years)

_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____ **Age**:_____ **Gender:** Male____ Female _____

Marital Status:
Never Married____ Domestic Partnership____ Married ____
Separated ____ Divorced ____ Widowed____

Please list any
children/age:_____

Address:_____
(Street and Number)
_____

(City) (State) (Zip)
Home Phone:_____May we leave a message? Yes___No___

Cell/Other Phone:_____May we leave a message? Yes___No___

Email:_____May we email you? Yes___No___
*Please note:Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any):_____

Have you recently received any type of mental health services (psychotherapy, psychiatric services, etc?)
____Yes, previous therapist/practitioner:_____
No____

Are you currently taking any prescription medication? No___ If yes, Please list:_____

_____

Have you ever been prescribed psychiatric medication? No___ If yes, Please list:_____

_____

General Health and Mental Health Information

1. How would you rate your current mental health?

Poor____ Unsatisfactory ____ Satisfactory____ Good ____ Very Good ____

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate you current sleeping habits?

Poor____ Unsatisfactory____ Satisfactory____ Good ____ Very Good ____

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What type of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? Yes____ No____
If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
No____ Yes____
If yes, when did you begin experiencing this?_____

7. Are you currently experiencing any chronic pain?
No____ Yes____
If yes, please describe:_____

_____

8. Do you drink alcohol more than once a week? Yes____No____

9. How often do you engage in recreational drug use?
Daily____ Weekly ____ Monthly ____ Infrequently ____ Never ____

10. Are you currently in a romantic relationship? Yes____ No____
If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship?_____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

Please Check List Family Member

Alcohol/Substance abuse: Yes___ No___
Anxiety: Yes___ No___
Depression: Yes___ No___
Domestic Violence: Yes___ No___
Eating Disorders: Yes___ No___
Obesity: Yes___ No___
Obsessive Compulsive Behavior: Yes___ No___
Schizophrenia: Yes___ No___
Suicide Attempts: Yes___ No___

ADDITIONAL INFORMATION:

1. Are you currently employed? Yes____ No____

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current employment?

_____

_____

2. Do you consider yourself spiritual or religious? Yes ____ No ____

If yes, please describe faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

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CLIENT BILLING INFORMATION

EMERGENCY CONTACT INFORMATION REQUIRED IF CLIENT IS A MINOR: PLEASE LIST ANOTHER NON-CUSTODIAL CONTACT:

Name **Primary Phone**

Address **Relationship to Client**

Please check payment method:

Insurance _____ Cash _____ Check _____ Credit Card _____

If cash, please identify who is responsible for payments other than client: _____

_____

Primary Insurance **Policyholder's Name** **Relationship to client** **Policyholder DOB**

Contract/ID Number **Group Number** **Policyholder's Employer** **Policyholder SSN**

Secondary Insurance **Policyholder's Name** **Relationship to client** **Policyholder DOB**

Contract/ID Number **Group Number** **Policyholder's Employer** **Policyholder SSN**