Deb Christiansen Counseling, LLC

Licensed Mental Health Practitioner

Client Information

Client: (First partner if a couple) _____

Sex: Male____ Female ____ Age: _____Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Is it okay to leave a message on Cell? (Y) __ (N) __ Home? (Y) __ (N) __ Work? (Y) __ (N) ___
Is it okay to text you on this cell phone? (Y) __ (N) __

Email: _____ Okay to contact you via this email? (Y) __ (N) __

Legal Status: Single ___ Married ___ Separated ___ Divorced ___ Widow(er) ___ Minor ___ (Under 19 years)

Occupation: _____ Employer/School: _____

Education (highest level): _____ Graduation Year: _____

Current Living Situation: Alone ___ With Spouse/Partner ___ With Parents ___ With Children ___ With Friends _____

Emergency Contact: _____
Emergency Contact Phone: Home: _____ Work_____ Cell _____
I agree for this person to be contacted in an emergency (initial) _____

Spouse/Partner Name: _____

Sex: Male____ Female ____ Age: _____Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____
Is it okay to leave a message on Cell? (Y) __ (N) __ Home? (Y) __ (N) __ Work? (Y) __ (N) ___
Is it okay to text you on this cell phone? (Y) __ (N) __

Email: _____ Okay to contact you via this email? (Y) __ (N) __

Occupation: _____ Employer/School: _____

Education (highest level): _____ Graduation Year: _____

Name(s) of Children	Age	Sex	School/College/Employed	Living with you?
1.				(Y) ___ (N) ___
2.				(Y) ___ (N) ___
3.				(Y) ___ (N) ___
4.				(Y) ___ (N) ___
5.				(Y) ___ (N) ___
6.				(Y) ___ (N) ___

Reason for seeking services: _____
_____
_____
_____

Current Family Physician: _____ Phone # _____

Family Medical History & Current Medical/Surgical Problems? _____
_____
_____

Current Medications: _____
_____

Are you compliant with Meds? _____

Are currently involved in the legal system? (YES) ____ (N0) ____
If Yes, Please give details: _____
_____
_____

Have you seen a Mental Health Professional before? (YES) ____ (NO) ____
If Yes, Please list Symptoms, Diagnosis, and Treatment received:_____
_____
_____

Are you currently seeing a Mental Health Professional? (YES) ____ (NO) ____
Therapist/Psychologist/Psychiatrist: _____ Phone # _____
Therapist/Psychologist/Psychiatrist: _____ Phone # _____

Name of Primary Insurance: _____ Member # _____

Insured's Name: _____ SS#: _____

Name of Secondary Insurance: _____ Member # _____

Insured's Name: _____ SS#: _____

Responsible Party for Billing: _____

Signature of Clients' (or Legal Guardian): _____

Date: _____