Clovis Counseling

SCREENING INFORMATION

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Client Information

Date: _____/_____/_____ Client's Social Security # _____-_____-_____

Client's First Name _____ Last Name _____ MI ____

Address _____ City _____ State____ Zip _____

Phone (Home) _____ (Work) _____

Birth date _____/_____/_____ Age _____ Gender ☐ F ☐ M Ethnicity _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State____ Zip _____

Payment Information

I hereby accept full responsibility for payment of all services rendered on behalf of above client:

Name _____ Soc. Sec. # _____-_____-_____

Signature of Person Responsible for Payment X _____

(Must be signed for services to begin)

Employment Information

If client is a child, use parent's employment

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

(PLEASE COMPLETE BACK OF FORM ALSO)

Clovis Counseling

Emergency Contact Information

Name(1) _____ Relationship _____

Phone (Home) _____ (Work) _____

Address _____ City _____ State____ Zip _____

Name(2) _____ Relationship _____

Phone (Home) _____ (Work) _____

Address _____ City _____ State____ Zip _____

Physician _____ Phone _____

Address _____ City _____ State____ Zip _____

Psychiatrist _____ Phone _____

Address _____ City _____ State____ Zip _____

Other Physicians _____ Phone _____

Current Medications _____

Allergies _____

Referral Source

How did you hear about Clovis Counseling? _____

Address _____ City _____ State____ Zip _____

Phone _____ Relationship to referral source _____