# Arbor Counseling

**208 West Pointe Drive, Suite B Swansea, IL 62226**

**Adult Client Information** **Today's date: _____**

**Your name**: _____Date of birth: _____

Driver's License #: _____ Social Security #: _____

Home street address: _____ Apt.:_____

City:_____ State: _____Zip: _____

Home/evening phone: _____ Can we leave a message at this number? YES NO

Cell Phone: _____ Can we leave a message at this number? YES NO

**Employer**: _____Occuptaion: _____

**Work phone**: _____Can we leave a message at this number? YES NO

**Spouse**:_____ Spouse'sEmployer: _____

Address if different than above: _____
Street City State Zip

Contact phone: _____ Can we call/leave a message at this number? YES NO

**Payment Information**

Primary Policy Holder: _____ Relationship to Client: _____

Primary Policyholder Date of birth: _____ Primary Policyholder Employer_____

Address if different than above: _____ Apt._____

City: _____ State: _____Zip: _____

_____
Insurance Company Member ID #. Group or Policy #

_____
Billing Address Phone Employer

_____
Secondary Insurance Company Member ID # Group or Policy No.

_____
Billing Address Phone Employer

**Referral:** Who gave you our name to call?

Name: _____ Phone: _____

Address: _____

May we have your permission to thank this person for the referral? • Yes • No

_____
Client Signature Date

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## Brief Health Information Form

**Identification**

Client's name: _____ Date: _____

**Health History**

Please list any illnesses that may be interfering with your current functioning. Be sure to include any head trauma, history of seizures, and significant adult or childhood illnesses.

| Age of Onset | Illness/diagnosis | Treatment received | Treated by | Outcome |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Describe any allergies you have.

| To what? | Reaction you have | Allergy medications you take |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List all medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

| Medication/drug | Dose (how much?) | Taken for | Prescribed & supervised by |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**What are your primary reasons for seeking counseling?**

_____

_____

**Primary Care Physician (Name, address & Phone)**

_____

_____

_____

_____

**Please check the appropriate box below:**

May I have your permission to inform him/her of your involvement in counseling? • Yes • No

May I have your permission to discuss with your physician any treatment concerns, evaluations, needs and/or progress? • Yes • No

Signature & Date_____

I acknowledge that I am familiar with my privacy rights through HIPPA, and understand that if I have any questions or wish to receive a written copy of this office's privacy policy, I can ask my therapist for one.

Signature and Date _____