

CLIENT INFORMATION FORM

PLEASE PRINT – complete all items that apply

A. CLIENT'S NAME: _____ BIRTHDATE: _____ SSN: _____

ADDRESS: _____ HOME PHONE: _____

E-MAIL ADDRESS (IF USED REGULARLY): _____ CELL PHONE: _____

OCCUPATION: _____ EMPLOYER: _____ WORK PHONE: _____

ADDRESS OF EMPLOYER: _____

MARITAL STATUS SINGLE MARRIED (DATE: _____) DIVORCED (DATE: _____)

SEPARATED (DATE: _____) WIDOWED (DATE: _____) LIVING TOGETHER

SPOUSE/PARTNER'S NAME _____ MAY WE CONTACT HIM/HER IN AN EMERGENCY? Y / N

NAMES/AGES OF DEPENDENTS/CHILDREN _____

IN CASE OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBERS: _____

IN A FEW WORDS, WHAT BRINGS YOU IN FOR SERVICES? _____

CIRCLE ANY OTHER RELATED DIFFICULTIES:

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SUICIDAL THOUGHTS | <input type="checkbox"/> ANXIETY/PANIC | <input type="checkbox"/> STRESS | <input type="checkbox"/> MARITAL PROBLEMS |
| <input type="checkbox"/> FAMILY PROBLEMS | <input type="checkbox"/> EATING DISORDER | <input type="checkbox"/> ALCOHOL/DRUG | <input type="checkbox"/> PHOBIAS/FEARS | <input type="checkbox"/> SEXUAL DYSFUNCTION |
| <input type="checkbox"/> CAREER/WORK ISSUES | <input type="checkbox"/> SLEEP PROBLEMS | <input type="checkbox"/> PHYSICAL/EMOTIONAL/SEXUAL ABUSE | <input type="checkbox"/> RELATIONSHIP ISSUES | |
| <input type="checkbox"/> PAIN | <input type="checkbox"/> HEALTH PROBLEMS: _____ | | | |

OTHER: _____

DATE CURRENT CONCERNS STARTED: _____ ARE THESE RELATED TO EMPLOYMENT OR AN ACCIDENT? Y / N

IF YES, PLEASE EXPLAIN: _____

HAVE YOU BEEN UNABLE TO WORK? Y / N IF YES, WHEN? _____

HAVE YOUR CONCERNS RESULTED IN HOSPITALIZATION? Y / N IF YES, WHEN? _____

HAVE YOU HAD SIMILAR CONCERNS BEFORE? Y / N IF YES, WHEN? _____

WHAT DO YOU THINK CAUSED THESE DIFFICULTIES? _____

DESCRIBE LIFE EVENTS OR CHANGES THAT HAVE OCCURRED IN THE PAST YEAR (e.g., job changes, death in the family, Divorce, child entering/leaving school, serious illness, financial problems, etc.): _____

LIST CURRENT MEDICATIONS AND DOSES: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

May we have your permission to consult with your physician? Y / N

WHO REFERRED YOU TO DR. BURKE? _____

WHEN WAS THE LAST TIME YOU SAW HIM OR HER? _____

MAY WE CONTACT THEM AND THANK THEM FOR THE REFERRAL? Y / N

MENTAL HEALTH HISTORY – PLEASE INDICATE IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING

OUTPATIENT TREATMENT (COUNSELING/PSYCHOTHERAPY): Y / N (IF YES, WHEN? _____)

PSYCHIATRIC HOSPITALIZATION: Y / N (IF YES, WHEN? _____)

ALCOHOL/DRUG TREATMENT: Y / N (IF YES, WHEN? _____)

PHYSICAL/EMOTIONAL/SEXUAL ABUSE: Y / N (IF YES, WHEN? _____)

SUICIDAL THOUGHTS: Y / N (IF YES, WHEN? _____)

SUICIDE ATTEMPTS: Y / N (IF YES, WHEN? _____)

FAMILY HISTORY OF MENTAL HEALTH OR SUBSTANCE ABUSE PROBLEMS: Y / N (IF YES, WHEN? _____)

WHAT DO YOU EXPECT TO GET OUT OF THIS TREATMENT OR EVALUATION? _____

HOW WOULD YOU LIKE YOUR LIFE TO BE DIFFERENT? _____

B. PLEASE COMPLETE THE FOLLOWING INFORMATION IF THE CLIENT'S INSURANCE IS UNDER ANOTHER INSURED'S NAME OR IF SOMEONE OTHER THAN THE CLIENT WILL BE RESPONSIBLE FOR PAYMENT (SUCH AS A SPOUSE OR PARENT):

INSURED'S/RESPONSIBLE PARTY'S NAME: _____ BIRTHDATE: _____ SSN: _____

ADDRESS: _____ HOME PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS OF EMPLOYER: _____ WORK PHONE: _____

C. IF YOU (OR YOUR SPOUSE) HAVE INSURANCE, PLEASE FILL IN THE NUMBERS AND NAMES FOR EACH ONE.

1. PRIMARY INSURANCE COMPANY: _____ NAME OF POLICY HOLDER: _____
(SECTION B ABOVE MUST BE COMPLETED FOR THIS INDIVIDUAL IF IT IS NOT THE CLIENT)

POLICY #/ID: _____ GROUP/CERTIFICATE #: _____

PHONE: _____ NAME OF GROUP (OFTEN THE EMPLOYER): _____

ADDRESS TO SEND CLAIMS: _____ TYPE OF INSURANCE: _____
(individual, group, workers' comp, EAP, other)

IF WORKERS' COMPENSATION, INDICATE DATE OF ACCIDENT, WHO AUTHORIZED TREATMENT, AND OTHER RELEVANT INFORMATION:

2. SECONDARY INSURANCE COMPANY: _____ NAME OF POLICY HOLDER: _____
(SECTION B ABOVE MUST BE COMPLETED FOR THIS INDIVIDUAL IF IT IS NOT THE CLIENT)

POLICY #/ID: _____ GROUP/CERTIFICATE #: _____

PHONE: _____ NAME OF GROUP (OFTEN THE EMPLOYER): _____

ADDRESS TO SEND CLAIMS: _____ TYPE OF INSURANCE: _____
(INDIVIDUAL, GROUP, WORKERS' COMP, EAP, OTHER)

D. IF YOU DO NOT HAVE INSURANCE, HOW WILL YOU PAY FOR SERVICES FROM THIS OFFICE?

E. I GIVE THIS OFFICE PERMISSION TO RELEASE ANY INFORMATION OBTAINED DURING EXAMINATIONS OR TREATMENT OF THIS CLIENT THAT IS NECESSARY TO SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT AND SECURE TIMELY PAYMENTS DUE TO THE ASSIGNEE OR MYSELF.

F. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE.

G. ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN MEDICAL BENEFITS, INCLUDING THOSE FROM GOVERNMENT-SPONSORED PROGRAMS AND OTHER HEALTH PLANS, TO BE PAID TO PHILIP BURKE, PHD. MEDICARE REGULATIONS MAY APPLY. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS GOOD AS THE ORIGINAL.

Client's (or parent/guardian's) signature,
indicating agreement to all of the
statements above

Printed name

Date

Insured's/responsible party's signature
(if different from client), indicating
agreement to all of the statements above

Printed name

Date