

# HARMONY COUNSELING SERVICES

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## CLINICAL INFORMATION FORM

Thank you for allowing me to provide services. I look forward to providing you with professional therapy services. Please take a few minutes to complete this form. The information will help me to better understand your circumstances and work with you to find solutions. Please note the information is confidential, for clinical use only, and will not be release without your written permission.

### Client information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Religious Affiliation (if any) \_\_\_\_\_ Highest Grade Completed: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Is it okay to leave a message at these numbers?  Yes  No

Email Address \_\_\_\_\_ May we send you e-mail relevant to you care?  Yes  No

### Partner Information (or parent information if client is a minor)

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employee: \_\_\_\_\_ Occupation: \_\_\_\_\_

Religious Affiliation (if any) \_\_\_\_\_ Highest Grade Completed: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Is it okay to leave a message at these numbers:  Yes  No

Email Address \_\_\_\_\_ May we send you e-mail relevant to your care  Yes  No

**Insurance information (if insurance is being billed by the therapist)**

Name of Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Owner of Policy: \_\_\_\_\_ Policy or Group#: \_\_\_\_\_

Policy Owner's Date of Birth: \_\_\_\_\_ Insurance Co. Phone #(Mental Health): \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

**Marital Status**

- Single, never Married*  *Remarried, How Long:* \_\_\_\_\_
- Single, Divorced, How Long* \_\_\_\_\_ *How many times have you been married?* \_\_\_\_\_
- Single, Widowed, How Long* \_\_\_\_\_
- Married, How Long* \_\_\_\_\_

**Family Information**

Additional Family Members (Including adult children)

Child Name:	Sex:	Age:	With whom child lives

List of other individuals living in the home:

\_\_\_\_\_

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis

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**Presenting Problem**

Please list the reasons that bring you here today. This may include certain problems, issues, significant losses or changes that are causing you stress.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

**Risk Assessment**

Please list family, friends, support groups, and community groups that are helpful to you.

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List any history of emotional, physical, and/or sexual abuse.

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Have you been having any thoughts of harming yourself or others? No  Yes  Self  others(s)

Are there any guns or weapons in your house (please list)? \_\_\_\_\_

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation) if so, please explain. \_\_\_\_\_

Are you or anyone in your home experiencing any emotional or physical violence in the home? Yes \_\_\_\_ No \_\_\_\_

**Medical History & Information**

Are you currently being treated by a physician for any medical conditions? If so, please describe.

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Are you currently taking medication?  Yes  No

Medication name/dose \_\_\_\_\_

**Previous or Current Counseling**

Have you ever seen a psychiatrist or any mental health provider?  Yes  No

Was it helpful?  Yes  No

When were you treated and what was the primary focus of the sessions?

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**Emergency Information**

Emergency Contact Person

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Phone Number(s): \_\_\_\_\_

Do I have permission to contact that person in the event that you require emergency assistance?  Yes  No

**Referral Sources**

How did you learn about this office: (Please check one and provide name as indicated).

Friend \_\_\_\_\_  Physician \_\_\_\_\_  Advertising (source) \_\_\_\_\_

Internet \_\_\_\_\_  Other \_\_\_\_\_

Thank you for the time to fill out this form.

Client's name (please print): \_\_\_\_\_

Client's (or guardian's) signature: \_\_\_\_\_ Date \_\_\_\_\_