CINDY THELEN, LCPC, CT
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CLIENT INFORMATION FORM

NAME _____ TODAY'S DATE _____

HOME ADDRESS _____

CITY _____ ZIP _____

HOME PHONE (_____)_____ CELL PHONE (_____)_____ WORK PHONE (_____)_____

DATE OF BIRTH _____ EMAIL _____

EMERGENCY CONTACT NAME & PHONE _____

_____

MAY I SEND CORRESPONDENCE OR LEAVE MESSAGES?

Home address	❒ Yes	❒ No
Home phone	❒ Yes	❒ No
Cell phone	❒ Yes	❒ No
Email	❒ Yes	❒ No

REFERRED BY / HOW DID YOU FIND ME?

_____

_____

INSURANCE INFORMATION: *PLEASE COMPLETE IF YOU ARE UTILIZING INSURANCE. IF POSSIBLE, ATTACH COPY OF BOTH SIDES OF YOUR ID CARD.*

INSURANCE PROVIDER _____ PPO OR HMO _____

INSURED NAME _____ RELATIONSHIP TO INSURED _____

INSURED PHONE & ADDRESS (IF DIFFERENT) _____

INSURED ID # _____ INSURED DATE OF BIRTH _____

GROUP NUMBER _____ EFFECTIVE DATE _____

DEDUCTIBLE & CO-PAY AMOUNT $_____

INSURANCE PHONE # FOR PROVIDERS _____

SEND CLAIMS TO _____

Please provide the following information for us to review during our therapy sessions. This form is for initial information-gathering only and is confidential. You will not be judged by your answers, nor expected to maintain the status quo. Leave blank any question you would rather not answer and feel free to add any other information you think might be useful.

Describe briefly what brings you to counseling/therapy.

What are your goals for therapy / how will you know if it is helping?

Have you ever been in counseling/therapy before? How was it?

What are your hopes about therapy?

What are your fears, if any, about therapy?

How would you describe your most important relationships?

Who lives in your household (# of people / ages / relationships)?

Please describe the strategies you most often use for coping with stress.

How is your physical health?

Please list any significant (to you) accidents, surgeries, and hospitalizations with date/year.

Do you have any chronic medical or physical conditions? ❒ Yes ❒ No
If yes, what are they and how do they affect you?

How is your sleep?

How do you feel about how you eat?

What is your daily caffeine intake?

What kinds of exercise do you get, and how often?

Please list other health care practitioners with whom you are currently working.

Please list medications or supplements you are currently taking.

Please describe briefly your spiritual practices/beliefs, if any.

Please comment on any significant life experiences that have had an important effect on you.

What other information would be of value to me in helping you?

Thank you for sharing this information. It will be held in confidence.