CLEARWATER
COUNSELING

Client Information

First Name_____ Last Name_____ Middle Initial___
Date of Birth _____ SSN _____-_____-_____ Marital Status: S__ M__ D__ W__
Street Address_____ City_____ Zip code_____
Home Phone_____Work Phone_____ Cell Phone_____
Employer/School_____ Employment Status: Full time / Part time / Seasonal

Client was referred to Clearwater by _____

Financially Responsible Party

Client relationship to insured or responsible party: (circle one) Self Spouse Child Other
Is the client covered by healthcare insurance? (circle one) Yes No

First Name_____ Last Name_____ Middle Initial___
Date of Birth _____ SSN _____-_____-_____ Marital Status: S__ M__ D__ W__
Street Address_____ City_____ Zip code_____
Home Phone_____Work Phone_____ Cell Phone_____
Employer/School_____ Employment Status: Full time / Part time / Seasonal

***Client acknowledges that Clearwater Counseling will not be submitting any claims on client's behalf, and is out of network with all insurance companies. Please initial** _____

Medical History and Physician Information

Primary Physician_____ Psychiatrist Name_____
Address _____ Address_____
City/State/Zip_____ City/State/Zip_____
Phone_____ Phone_____

Client's current condition of health: Height_____ Weight_____
Change in weight in past year More / Less
General Health: Excellent Good Fair Poor **Vision:** Excellent Good Fair Poor
Hearing: Excellent Good Fair Poor

Comments:

Date of last physical / Physician visit: _____ Name of Physician_____

Current Medications: (including over-the-counter medications you take regularly)

Medication	Dosage & Frequency	Start Date	Prescriber

Please list any physical symptoms you are currently experiencing (within past 6 months)

Please list any significant medial conditions you have ever experienced:

Please list any known allergies:

Please list any hospitalizations you have experienced (Dates, length of stay, and reason):

Current alcohol usage (per week) _____
Current tobacco usage (per week) _____
Current recreational substances (substance and amount per week) _____

History of above substance usage_____
_____
_____

Have you ever taken medication for psychiatric/behavioral reasons? ____ Yes _____ No

I consent for Clearwater Counseling Group to contact the physician(s) listed above for the following purposes: to share clinical information regarding my initial sessions at Clearwater (including presenting problem, diagnostic / assessment information, and treatment goals); to receive clinical/medical information from the physician that may be helpful for successful treatment. Please initial ____ Yes ____ No

The information I have given today is correct to the best of my knowledge. I understand that it is my responsibility to inform my therapist of any changes in my medical status or contact information. As a parent of guardian of a minor client, I am consenting for the above named minor to receive treatment at Clearwater Counseling Group. I understand that I am responsible for the prompt payment of fees associated with this account.

_____ _____

Client (or Gaurdian) Signature **Date** **Therapist Signature** **Date**