

**Geri Magee, M.A. , CEP, CSA**

**Registered Counselor**

**Circle Creek Professional Bldg.**

**6212 75<sup>th</sup> Street West Suite #2**

**Lakewood, WA 98498**

**CONFIDENTIAL CLIENT INFORMATION**

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

WORK PHONE CELL \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SOC.SEC.# \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS CITY ZIP \_\_\_\_\_

( ) SINGLE ( ) MARRIED: HOW LONG? \_\_\_\_\_ ( ) COUPLED, NOT MARRIED: \_\_\_\_\_

( ) SEPARATED ( ) DIVORCED: HOW LONG? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

( ) WIDOWED ( ) PREVIOUS MARRIAGES: HOW MANY? \_\_\_\_\_

PARENT/SPOUSE OR

PARTNER \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE EMAIL

ADDRESS \_\_\_\_\_ APT # HOME PHONE

CITY ZIP WORK PHONE CELL

EMPLOYER \_\_\_\_\_

SOC.SEC. # \_\_\_\_\_

**CHILDREN:**

NAME \_\_\_\_\_ BIRTHDATE M/F SOC. SEC.# \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE M/F SOC. SEC.# \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE M/F SOC. SEC.# \_\_\_\_\_

RESPONSIBLE PARTY *IF OTHER THAN YOURSELF* \_\_\_\_\_

RELATIONSHIP TO CLIENT:

**INSURANCE INFORMATION:** *(Please be sure to bring a copy of front and back of insurance card to 1<sup>st</sup> appointment)*

**IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING COPAY AMOUNT AND AUTHORIZATION REQUIREMENTS.**

**PRIMARY INSURANCE:**

INSURED'S NAME \_\_\_\_\_

RELATIONSHIP TO CLIENT:

INSURANCE COMPANY \_\_\_\_\_

POLICY/GROUP NO \_\_\_\_\_.

INSURANCE BILLING ADDRESS \_\_\_\_\_  
\_\_\_\_\_

INSURED'S I.D. NO \_\_\_\_\_

INSURED.S BIRTH DATE \_\_\_\_\_

**SECONDARY INSURANCE:**

INSURED'S NAME \_\_\_\_\_

RELATIONSHIP TO CLIENT:

INSURANCE COMPANY \_\_\_\_\_

POLICY/GROUP NO. \_\_\_\_\_

INSURANCE BILLING ADDRESS \_\_\_\_\_

INSURED'S I.D. NO. \_\_\_\_\_

INSURED.S BIRTH DATE \_\_\_\_\_

**FINANCIAL RESPONSIBILITY:**

**I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES  
RENDERED IRREGARDLESS  
OF INSURANCE COVERAGE.**

X \_\_\_\_\_

Signature of Responsible Party

**PLEASE COMPLETE OTHER SIDE**

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE  
DATES, NAME(S) OF  
THERAPIST AND NATURE OF PROBLEM.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE DESCRIBE THE PRESENT PROBLEM:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

---

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?

---

---

---

---

---

---

---

---

PLEASE DESCRIBE ANY HEALTH PROBLEMS.

---

---

---

---

---

---

---

---

DO YOU SMOKE: ( )YES ( )NO                      SPOUSE/PARTNER: ( )YES ( )NO

DO YOU DRINK ALCOHOL? ( )YES ( )NO      SPOUSE/PARTNER: ( )YES ( )NO

WHAT KIND/HOW MUCH/HOW OFTEN? \_\_\_\_\_

DO YOU USE ANY OTHER SUBSTANCES? ( )YES ( )NO

SPOUSE/PARTNER: ( )YES ( )NO

WHAT KIND/HOW MUCH/HOW OFTEN? \_\_\_\_\_

(i.e. MARIJUANA, COCAINE, ETC.)

ARE YOU TAKING ANY MEDICATION? ( )YES ( )NO

SPOUSE/PARTNER: ( )YES ( )NO

DESCRIBE \_\_\_\_\_

DO YOU HAVE ANY TROUBLE SLEEPING?( )YES ( )NO

SPOUSE/PARTNER: ( )YES ( )NO

DESCRIBE \_\_\_\_\_

RECENTLY GAINED ( ) OR LOST ( ) WEIGHT?

HOW MUCH/OVER HOW LONG? \_\_\_\_\_ / \_\_\_\_\_

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR  
PSYCHOLOGICAL ILLNESS? ( )YES ( )NO

DESCRIBE \_\_\_\_\_

---

NAME OF PHYSICIAN \_\_\_\_\_ Ph# \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_