Lisa Spurling, LCMHC

Please Print Clearly **THIS SHEET MUST BE FILLED OUT COMPLETELY**

Date_____ Referred by:_____

Client's First Name_____MI_____ Last Name_____

Address_____ City_____ State_____ Zip

Client's Social Security #_____Birthdate____/____/____Age_____Gender __F __M

Home__(_____) _____ok to leave m Y / N_____

Work__(_____) _____ok to leave M Y / N_____

Cell __(_____) _____ok to leave M Y / N_____

Please check if you are: Employed ___ Unemployed___ Student ____ Disabled ___ Retired___ Homemaker ____

Occupation: _____ Employer:_____

Address of employment:_____

Phone(____)_____Hours _____

In case of emergency, contact:

Name (1) _____ Relationship_____

Home Phone(____)_____Work Phone(____)_____

Address_____ City_____ State_____ Zip_____

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Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Providers_____ Phone_____

Address_____

Insurance Information

Person Responsible for Payment_____Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____(Must be signed for services to begin)

Primary Insurance_____Phone (___)_____

Contract/ID#_____Group/Acct#_____

Subscriber_____Subscriber Date of Birth ____/____/____

Client's relationship to Subscriber: Self __Spouse __Child __Other_____

Secondary Insurance_____Phone (___)_____

Contract/ID#_____Group/Acct#_____

Subscriber_____Subscriber Date of Birth ____/____/____

Client's relationship to Subscriber: Self __Spouse __Child __Other_____

I authorize use of this form on all my insurance submissions. I authorize release of information to my insurance company.

I authorize direct payment to Lisa Spurling for services provided.

Print Name:_____Signature: _____

Date:_____

PLEASE TURN OVER

Please complete the following:

Briefly describe your reason for seeking help

Current Medications:

Medication: Prescribed by:

Medication: Prescribed by:

Medication: Prescribed by:

Allergies

Have you ever had mental health treatment before?

Have you had any mental health visits from another provider during the last 12 months?

Please tell me about your history of mental health treatment:

Have you ever been hospitalized for psychiatric reasons?_____ If yes please list dates, place and reasons

Martial History:

Please list members of your family and all others who live in your home:

Name	Age	Relationship	Occupation