

# Lisa Spurling, LCMHC

**Please Print Clearly**

**THIS SHEET MUST BE FILLED OUT COMPLETELY**

Date \_\_\_\_\_ Referred by: \_\_\_\_\_  
Client's First Name \_\_\_\_\_ MII \_\_\_\_\_ 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 \_\_\_\_\_  
\_\_\_\_\_

Marital History: \_\_\_\_\_  
\_\_\_\_\_

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

| <u>Name</u> | <u>Age</u> | <u>Relationship</u> | <u>Occupation</u> |
|-------------|------------|---------------------|-------------------|
| _____       | _____      | _____               | _____             |
| _____       | _____      | _____               | _____             |
| _____       | _____      | _____               | _____             |



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