

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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