Rebecca Tillemans, MS LCPC

CONFIDENTIAL CLIENT INFORMATION -- Adult

Client Name:_______________________________________ Intake Date:_____/______/_______

Address:____ Date of Birth_____/______/________

City:____ State: MD

Zip:________________

PHONE/CONTACT INFORMATION:

Home: ____________________________________ Cell: ____________________________________

Work: ____________________________________ Email: __________________________________

Preferred means of contact:
____

Emergency Contact:___________________________________Phone:____________________________

Relationship to you:__________________________________ Who referred you?__________________

Primary Care Physician _______________________________Phone: ____________________________

Employer:____ Occupation:_______________________

I understand that unless other arrangements are made, all fees are due at the time of service. I agree to accept financial responsibility for all charges, including missed appointment fees with less than 24 hours notice. I authorize the release of any information necessary to process my insurance claims with my carrier. Any statement balance billed is due and payable upon receipt.

Who is responsible for this account (guarantor)? ____

Guarantor Signature:___________________________________ Date: ______/______/____________

If you are not the Guarantor on this account, please give name and contact number of Guarantor below:

Guarantor: ____________________________________ Relationship to you:________________________

Phone:_______________________________________

Address:___________________________________

____

If you'd like me to keep a credit card number on file for you, please fill in the following:

Card type: ______________________

Card Number:____ Exp date:_____________________

Are you currently receiving treatment for a medical condition? Yes ___ No____ If yes, please explain:
____

____

Have you had prior psychotherapy, mental health or substance abuse counseling? Yes___ No___ If yes, please indicate when and with which provider(s): ____

____

Please indicate any Psychoactive Medications you are currently taking:

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Please indicate any Non-Psychoactive Medications or supplements you are taking, and for which condition:

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____

Please indicate which of these issues are concerning you today:

___ Depression, unhappiness
___ Anxiety, worry, nervousness
___ Panic attacks
___ Memory problems
___ Illness or chronic pain
___ Anger Management problems
___ Grief, loss
___ Trauma
___ Mood swings
___ Irritability
___ Lack of assertiveness
___ Marital/relationship issues
___ Sleep problems
___ Appetite problems
___ History of abuse
___ Few friends, loneliness
___ Lack of direction
___ Anger management
___ Alcohol or substance abuse
___ Divorce or separation issues
___ Legal problems
___ Financial problems
___ Disorganization
___ Difficulty concentrating
___ Procrastination
___ Time management problems
___ Victim of a crime
___ Parenting issues
___ Body image concerns
___ Excessive video game use

Please indicate any other concerns or give additional information that you think would be helpful:

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