

BIOGRAPHICAL INFORMATION

(So to better help you, please complete a separate biographical sheet for each client.)

Date of Your First Appointment: _____, 20__

Full Name: _____

Name you prefer to be called: _____ D.O.B. _____ Age: _____

Mailing Address: _____

Physical Address if different than above:

How did you learn of CCIA? _____

If it was an ad, where did you see/hear the ad?

HOW WE CAN CONTACT YOU:

		<input checked="" type="checkbox"/> Preferred Contact
Voice	Cell Phone (____) _____	[]
	Work Phone (____) _____	[]
	Home Phone (____) _____	[]

Email _____

Because we take your privacy and confidentiality seriously:

May CCIA contact you via:

	Email?	Yes	No
May we leave a Voice mail at:	Home	Yes	No
	Work	Yes	No
	Cell	Yes	No

Should CCIA need to mail something to you, may we do so via your home address?
(Only CCIA or your therapist's name & return address appears on envelopes.)

Yes No

If you prefer an Alternate Address, please list it here:

WHERE YOU WORK / GO TO SCHOOL:

Employer _____

Occupation _____

City where you work: _____

How long have you been with this employer/business? _____

IF STUDENT: School and Grade _____

MENTAL HEALTH HISTORY

Are you currently seeing, or have you ever seen, a psychiatrist, psychologist, or counselor? Please give their name, approximate months seen, and primary purpose of visits.

Have you ever attempted suicide? _____ Have you ever had suicidal thoughts? _____

Do you use medication/substances (whether prescribed, OTC, or recreational drugs) or dietary supplements? (Please list name, purpose, and frequency)

Have you ever been hospitalized due to mental illness?
(If so, list dates and name of hospital and physician.)

What is the primary reason that brings you here today? Include any goals you have for counseling.

Financial, and Emergency Contact Information

If paying by credit card, please present your card to be manually swiped.
PAYMENT IS MADE AT THE BEGINNING OF EACH SESSION.

In order to keep rates affordable, check or cash is the preferred method of payment.

HOW DO YOU PLAN TO HANDLE PAYMENT FOR COUNSELING SERVICES?

Cash Check MasterCard Visa FSA
**(Payable to
CCIA LLC)**

Your Emergency Contact Information (Required) If you are in couples counseling, please list a contact **other than** your spouse/partner.

Name of person: _____

Relationship: _____

Phone: _____ Alt. Phone: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

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