



Loganville Community Ministry Village

Adult Client Information Form

Name _____ Email Address _____

Address _____ City, State & Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____

Employer _____ Work Phone _____

Please indicate which number you prefer us to call and remind of appointments _____

Marital Status Single Married Divorced Separated Widowed

Name of Spouse _____ Age _____

Spouse's Employer _____ Date of Birth _____

Person Responsible for Payment _____
(if other than yourself)

Address _____ City, State, & Zip _____

Home Phone _____ Work Phone _____

List Children's Name & Ages

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Reason for your visit today

On a scale from 0 to 100 (100 being the best) how would you say things are at this time?

Do you have a good support system such as friends, church family etc. _____ if so who? _____

Is it ok with you if your counselor prays with you? _____

Emergency Contact _____ Phone Number _____

Relationship _____

Who referred you to our office? _____

Please give your insurance information and your insurance card to the receptionist.

**I authorize payment of medical benefits directly to therapist, realizing that I am responsible to pay non-covered services. I hereby authorize the release of information to insurance carriers. I understand that once LCMV releases information to the insurance carrier LCMV has no control over how this information is handled by them.

Client's Signature _____ Date _____

Client History

1. Have you ever been in any type of counseling before? _____

2. Have you ever been hospitalized for any type of mental health problems? If so, please give date and location _____

3. Is there a history of alcohol and/or drug abuse or mental illness in your family? If yes, please explain _____

4. Do you have a history of medical problems? Please list _____

5. Are you currently taking medications? Yes _____ No _____

6. Name of medication: _____ Dosage: _____

7. Prescribed by: _____ Start Date: _____

8. Please list physicians who are currently treating you

