

CONSULTANTS FOR CHANGE

733 E. Chapman Avenue
Fullerton, CA 92831
(714) 992-4656

Client Information

Client Name				Age
SSN			Date of Birth	/ /
Street Address	City	State	Zip	
Home phone ()	Cell phone ()	Work phone ()		
Can we contact you at home? Yes _____ No _____			Can we contact you at work? Yes _____ No _____	

Occupation	Current position		
Employed by	How long?		
Work Address	City	State	Zip

Name of person financially responsible				Age
SSN				
Street Address	City	State	Zip	
Home phone ()	Work phone ()			
Client=s relationship to responsible party:				

Briefly describe your reasons for seeking help

Who referred you to us?	
Name	Contact phone number ()
What is your relationship to referral source?	May we contact your referral source? Yes _____ No _____

Primary Insurance Company Name		Phone	
Street Address	City	State	Zip
Subscriber=s name			
Address	City	State	Zip
Subscriber=s employer		Phone	
Client relationship to insured			
Group Number	Subscriber Number	Policy Number	
Deductible \$ _____			

Marital status (check one)					
Single _____	Married _____	Divorced _____	Widowed _____	Other _____	
Is this your first marriage? Yes _____ 2 nd _____ 3 rd _____ 4 th _____ 5 th _____					
How old were you when you married? 1 st _____ 2 nd _____ 3 rd _____ 4 th _____ 5 th _____					
Duration of each marriage 1 st _____ 2 nd _____ 3 rd _____ 4 th _____ 5 th _____					
Current spouse=s name					
Spouse=s occupation			Employed by		

List all people currently living in your home Name	Age	Relationship	School/Occupation

Please circle all of the following areas in which you are having difficulty:

nervousness	depression	fears	anxiety
shyness	sexual problems	suicidal thoughts	panic attacks
divorce	boredom	finances	heart palpitations
drug use	alcohol use	friends	edgy
anger	self-control	unhappiness	intimacy
insomnia	stress	work	phobias
relaxation	headaches	dating skills	moodiness
legal matters	memory	assertiveness	having fun
low energy	isolation	making decisions	making friends
loneliness	self-esteem	concentration	inferiority
education	career choices	health problems	keeping a job
relationships	nightmares	marriage	irritability
children	eating problems	perfectionism	mood changes
bowel troubles	being a parent	my thoughts	family
Other: _____			

Other information that you think would be useful:

I authorize my therapist to release any medical information regarding the medical, mental health, or alcohol/drug abuse history, treatment, or benefits payable, including disability or employment related information to any insurance company, the Plan Administrator, or their authorized agents that I may have coverage with, for the purpose of validating and determining benefits payable for my treatment. This includes any information/reports that may be required by any managed care contracts associated with my insurance coverage. In signing this statement, I am aware that confidentiality regarding information given to managed care/insurance companies is relinquished. My confidentiality in this regard is protected only by the laws and ethics governing the managed care and insurance companies.

_____ Date

_____ Client signature (parent if client is a minor)