

CHRISTIAN COUNSELING ASSOCIATES, Inc.

STEVENS FOREST PROFESSIONAL CENTER
9650 Santiago Road, Suite 101
Columbia, MD 21045

(410) 995-5587 or (301) 596-5759
Fax (410) 992-1779
mail@ChristianCounselingAssociates.org

INTAKE INFORMATION FOR OUR BUSINESS OFFICE

This information will be part of your business records and will NOT be held in confidence by the counselor

CLIENT IDENTIFYING DATA:

DATE: _____

Full Name: _____ Birth Date _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address: _____
_____ SSN _____

City _____ State _____ Zip Code _____

Email Address (Optional): _____

| <u>Spouse/Children/Others in the home:</u> | <u>Relationship:</u> | <u>Birth Date:</u> | <u>Sex:</u> | <u>School/ Employer:</u> |
|--|----------------------|--------------------|-------------|--------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

EMERGENCY CONTACT: _____ Relationship _____ Phone _____

PERSONAL INFORMATION:

Date of Marriage: _____ Previous Divorce? _____ Highest Education Level completed _____

Employer(or School): _____ Address: _____

Occupation: _____ Total yearly family income: _____

How did you hear about Christian Counseling Associates, Inc.? _____

MEDICAL INFORMATION:

Primary Physician: _____ Address: _____

Phone: _____ Date of Last Exam: _____ Outcome of Exam: _____

Illnesses/Conditions (please include any psychiatric diagnoses): _____

Medications currently taking (please include dosages): _____

Known Allergies: _____

BILLING INFORMATION:

Who is responsible for payment of fees? _____

Address if different from above: _____

HEALTH INSURANCE INFORMATION:

PRIMARY Insurance Company Name: _____

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

Policy Holder's S.S#: _____ Employer: _____

Policy Number: _____ Group number: _____

Pre-Authorization needed? _____ Authorization Number _____ Client's Relation to Policy Holder: _____

Session Start Date _____ Session End Date _____ Number of Sessions Approved _____

Terms of Mental Health Benefits _____

SECONDARY insurance Company if any: _____

PLEASE BRING YOUR INSURANCE CARD FOR US TO PHOTOCOPY.

Please continue on the other side

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Our Staff Members Are Committed Christians and Fully Trained Professionals

THERAPY INFORMATION AND BACKGROUND

This information will be held by your therapist and will be considered CONFIDENTIAL.

Please describe briefly your reason for seeking counseling at this time:

When did this situation begin? _____

Have you previously sought counseling assistance? _____

From whom? _____

Please briefly describe that counseling, including its outcomes:

Any family history of:

Alcohol/drug abuse? Sexual abuse? Family violence? Other problem behavior?

Your History of use of Alcohol and/or other drugs (except for prescribed medications):

Your School and Work History:

Your Spiritual/Religious History: Please include Church attendance and participation

Your goals for counseling: What would you like your counselor to help you accomplish?

Thank you for filling out this information form before your first meeting with the counselor.