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Social Enrichment Institute LLC

Payment can be made with a personal check, cash, money order or credit card. If paying with a credit card the enclosed credit card sheet must be completed. The document will be secured in a locked area and will not be viewed or entered by anyone other than myself. Payments will be executed through INTUIT following each session. In the case of an evaluation payment must be received or processed 24 hours in advance of the evaluation (see payment information on disclosure form).

ADULT CLIENT INFORMATION

BASIC INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Marital Status: S / M / SP / D / W

City: _____ Zip: _____ Soc. Security #: _____

Phone Number: (h) _____ (w) _____ (c) _____

Emergency Contact: _____ Phone: _____

Relationship to you: _____

Referred by: _____ Phone: _____

Reason for Referral: _____

_____

EMPLOYMENT

Employer: _____ Job Title: _____

Employer's Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Family Information

Spouse/Partner: _____ Age _____ Marital Status: M / S / SP / D / W

Occupation: _____ Education Level: _____

Other: _____ Age _____ Marital Status: M / S / SP / D / W

Occupation: _____ Education Level: _____

CHILDREN IN HOME:

Child's Name: _____ Date of Birth: _____ Age: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Child's Name: _____ Date of Birth: _____ Age: _____

OTHER PEOPLE LIVING IN HOME:

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

If you have been previously married or involved in a long-term relationship, please indicate below:

Dates of previous relationship/marriage: _____

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Dates of previous relationship/marriage: _____

Medical Information

Physician's Name: _____ Phone: _____

Previous illnesses, injuries, hospitalizations: _____

_____

Are you currently under the care of a physician for any chronic or acute medical conditions: _____
If YES, please note:

_____

_____

Are you currently experiencing any of the following: difficulty sleeping, changes in weight (gain or loss), eating difficulties, restlessness, trouble concentrating

Current medications and dosages: _____

_____

Previous psychological evaluation? _____ If YES, give date(s) and evaluator(s):

_____

Psychological / Family History

Have you received previous outpatient treatment? _____
If YES, give approximate dates and therapist's name:

_____

Have you received previous inpatient treatment? _____
If YES, give date and name of hospital:

_____

Do any family members have a history of inpatient or outpatient psychiatric care? _____
If YES, list their relationship to you and condition (e.g. maternal aunt – depression):

_____

_____

Do any family members have a history of alcohol or drug abuse? _____
If YES, list their relationship to you:

_____

_____

Have you experienced any of the following, (please circle all that apply):

Domestic Violence	Sexual Abuse	Physical Abuse
Drug Addiction	Alcohol Abuse	Suicide Attempts
Anxiety	Depression	Eating Disorders

Consent:

I consent to treatment, certify that the above information is accurate, and authorize the release of medical information to other necessary parties.

_____ _____

Signature of Client Date