Roots to Wings, LLC

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Client Information:

Date of Initial Visit: ______________________________

Client Name: ____

Parent/Guardian (if applicable)____

If under 18, are parents married/divorced/separated/never married? (circle)

Legal and physical custody arrangement if divorced/separated/never married? ___________________________

Client's Age: ___________ Date of Birth: ____________________ Gender: ________________

Address: ____
Street

Address: ____
City State Zip Code

Home/Cell Telephone: ______________________Work Telephone: _________________________

Email address: ____

May I contact you at any of the above? _____ Yes _____ No

What are the concerns for which you are seeking help?_______________________________________

____

How did you learn about me? If you located the practice on a website, which one was it?

____

In case of emergency, who should be called? ____

Best contact number: ____

Would you like us to inform your Primary Care Doctor of your treatment here? ____________________

If so, name, address, and telephone of PCP:

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Is there anyone else with whom I may need to coordinate mental health services (ex: schools, psychiatrist, department of social services, family members, other counselors-past and present, etc.)? A Release of Information will need to be obtained for any information to be given or received on your behalf.

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For Adult Patients:

Employer: ____

Address: ____
Street

Address: ____
City State Zip Code

Total family income: ___________________________ Marital status: ______________________

If married, how long? _____________________ Number of times married: ____________

Name of spouse: _________________________________ Age of spouse: ___________________

Spouse's occupation: ____

If separated or divorced, since when? ____

Insurance:

BCBS Member ID # ____

I understand that I personally guarantee to be financially responsible to pay Roots to Wings, LLC for any and all charges rendered for services and any fees denied or unauthorized by insurance providers. I fully accept the services provided to the above named client as full consideration for my signing of this document. A copy of this document can be used in place of the original. I have read this document and I execute it with full knowledge and understanding of its contents.

____ ________________
Signature of client/guarantor Date

____
Relationship to patient