



Discover Your Destination • Choose Your Direction • Invite Traveling Companions

Client Information

Name: _____ Date of Birth: _____
Street Address: _____ City, State & Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____
Email Address: _____
Emergency Contact Name: _____ Phone Number: _____

How did you hear about us?

- Current or previous client
- Calvary Church pastor, therapist or staff member: _____
- Therapist or counselor: _____
- Friend or family member
- Phone Book
- Other: _____

Are you currently seeing a psychiatrist or Primary Care Physician for medication management?

Name and phone number of Provider: _____

Current Medications with dosages:

Insurance Information (if applicable)

Please call the customer service number on your insurance card to find out about your benefits. Please complete the attached *Release of Information to Insurance Carrier*

Insurance CarrierName and Phone Number: _____

Additional information (optional)

Please list your immediate family members (spouse or significant other, children and/or others living in your household):

<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>

	Strenths	Challenges/Limitations
Mental		
Emotional		
Spiritual		
Social		
Occupational		
Recreational		
Physical		