117A Tradewynd Dr.
Lynchburg, VA 24502
Phone 434-533-1660
Fax 866-201-2808

Client Information/Contact Form

Name: ___________________________________ **Referred by:** _________________________ **Date:**__________

Address: ___________________________ ___ **City:** __________________________**Zip Code:**___________

Phone: (Home)___________________ (Work)________________________ (Cell)______________________

Date of Birth: _________________ __**Age:**_____________**Ethnicity:**_____________________________

If minor, name of custodial parent(s):____

School: ____**Grade:** ____________________

Legal Issues?: _______________________________________**Probation Officer**________________________

County __________________ **Phone**_____________

Emergency Contact:________________________________**Phone:**___________________________

Preferred Language: ___English ___Spanish
Times and dates available for appointments: ____

Best time to call? ______________________________**May we leave a message at your home?** Yes No

Insured? : No Yes **Insurance Carrier/Number:** ____ **Medicaid Number:**___________________________

Type of Counseling Needed (check all that apply):
___ Individual (adult) ___Individual (child/adolescent) ___Family ___Therapeutic Mentoring ___Other

Briefly describe why you are seeking services (depression, family situation, anxiety, grief, etc.):

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Past History

Do you ever have: (please check mark conditions that apply to you)

___Anxiety ___Alcoholism ___Other________________

___Depression ___Drug Addiction ___Other________________

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___Anger ___Eating Disorder ___Other________________
___Grief/loss ___Post Traumatic Stress

Have you had any major illness, hospitalizations or surgeries?

Have you been treated for any health condition by a physician in the past year? ______Yes ______No
If yes, describe:____

Medications? (please list name and dosage)

Family History

Parents:

Father: living____deceased_____(check one) Current age if still living_________ Cause of death and age at death if deceased________________________________

Mother: living____deceased_____(check one) Current age if still living__________Cause of death and age at death if deceased________________________________

Check if applicable to you:_______I am adopted______As an adopted child, little is known of my birth parents or family

Family history of psychological/emotional difficulties:____

Family history of medical conditions:____

******************************For Office Use Only******************************

Referred to: _________________________ Date Referred:________________________
Court Ordered Counseling:
Dates client contacted to make appointment::_________________ ____________________ _________________ ______
Assigned Counselor: ____ **Date:** _____________________________
Notes:____ ___