# Wellspring of Life, LLC
## New Client Information Form

### *Personal Information* (All areas marked with a * MUST be completed)

*Client's Legal Name: _____ Nickname: _____
*First* *MI* *Last*

*Client's Home Address:

_____
*Street* *City* *State* *Zip*

*Client's E-mail Address: _____@_____

Client's Home Phone #: (_____)_____

Client's Business Phone #: (_____)_____

*Client's Main Cell Phone #: (_____)_____

Other Important Phone #: (_____)____ _____ *Type of # ?: _____

*Client's Social Security #: _____-_____-_____

*Client's Date of Birth: _____ /_____ /_____ Age: _____

*Client's Gender (circle one): Female Male

*Client's Martial Status (circle one): Single Married Other (**Other i**ncludes Divorced, Widowed & Domestic Partnerships)

*Client's School *OR* Work Status (circle only one):F/T Student P/T Student *OR* Employed Not Employed

### *Primary Insurance Information* (All areas marked with a * MUST be completed)

*Insurance Company Name: _____

Insurance Company Phone #: (_____)_____

*Subscriber's Name (if different): _____

*Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to Client: _____

*Subscriber's Employer: _____

*Subscriber's Insurance ID#: _____

*Subscriber's Group Policy/ID #: _____

*Subscriber's Phone # (if different): (_____)_____

*Subscriber's Address (if different):

_____
**Street** **City** **State** **Zip**

*Co-Payment Amount (Payment is required at appointment time): $_____

*Does the Client have an "Out-of-pocket deductible" for counseling? (circle one): Yes No

*Does the Client require a "Pre-Authorization" before counseling begins?(circle one): Yes No

Pre-Authorization Code (Provided by subscriber's insurance company): _____

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### ***Family Information*** **(All areas marked with a * MUST be completed)**

**Immediate Family Members :**

***Spouse's Name:** _____ **Age:** _____
*First MI Last*

**Spouse's Employer:** _____

**Spouse's Business Phone #:** (_____)_____

***Children/Siblings** **(First names & ages only):**

_____ _____

_____ _____

***Other Extended Family Members Living With Client:**

**Name:** _____ ***Relationship to Client:** _____

**Name:** _____ ***Relationship to Client:** _____

### ***Emergency Contact Information*** **(All areas marked with a * MUST be completed)**

***Name:** _____ ***Relationship to Client:** _____

***Contact Phone #1:** (_____)_____

***Contact Phone #2:** (_____)_____

***Emergency Address:**

_____
*Street City State Zip*

### ***Secondary Insurance Information*** **(All areas marked with a * MUST be completed)**

***Insurance Company Name:** _____

**Insurance Company Phone #:** (_____)_____

***Subscriber's Name (if different):** _____

***Subscriber's Date of Birth:** _____ /_____ /_____ ***Relationship to Client:** _____

***Subscriber's Employer:** _____

***Subscriber's Insurance ID#:** _____

***Subscriber's Group Policy/ID #:** _____

***Subscriber's Phone # (if different):** (_____)_____

***Subscriber's Address (if different):**

_____
*Street City State Zip*

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## *Mental Health Information* (All areas marked with a * MUST be completed)

*Reason(s) for seeking counseling (circle all that apply):

| | | |
|---|---|---|
| ADD/ADHD | Depression | Panic Attacks |
| Anger | Employment | Phobias |
| Anxiety | Family | Self Harm |
| Children | Gender | Sexuality |
| Chronic Pain | Grief/Bereavement | Stress |
| Compulsions | Medically Related | Substance Abuse |
| Couple/Marital | Obsessions | |

Other Issues (please specify): _____

*How long ago did the Client first experience the issue they are seeking counseling for?: _____

*Periods of prior counseling and/or psychiatric hospitalizations (if applicable): _____

*Prescribed Mental Health Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

## *Physical Health Information* (All areas marked with a * MUST be completed)

*Does the Client have a Primary Care Physician(circle one): Yes No

*Primary Care Physician's Name: _____

*Primary Care Physician's Phone #: (_____)_____

*Is the Client currently experiencing any chronic physical issues or limitations (circle one): Yes No

Briefly explain any physical issues:_____

*Does the Client smoke or use tobacco products?(circle one): Yes No How much per day?: _____

*Does the Client drink alcohol regularly?(circle one): Yes No How many drinks per day?: _____

*Prescribed Physical Health Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

*I hereby certify that the subscriber listed in this document has active behavioral health coverage with _____ Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to_____ .

I further understand that if the subscriber's behavioral health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize _____ to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically.

*Client (or guardian) signature: _____ Date: _____