Section I Client Information

First Name _____ Last Name _____ Middle Initial ___ Male / Female
Date of Birth _____ Social Security # _____-_____-_____ Marital Status S __ M __ D __ W __
Street Address _____ City & ZIP _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer/School _____ Employment Status: full time / part time / temp / seasonal

Client was referred to Crossroads by _____
May we send a brief "thank you" to this person for their referring you to us? (Initial one) Yes____ No____

Section II Financially Responsible Party* or Primary Subscriber of Insurance Information

Client relationship to insured or responsible party: (circle one) Self Spouse Child Other
Is the Client covered by healthcare insurance? (Circle one) Yes No

If Client is the primary subscriber, go to Section III. If Client relationship to the primary subscriber is **other** than self, please complete the following. *Please note, if you are of legal age to consent to treatment, even though your insurance may be through your spouse, parent, or other adult, you are still the financially responsible party.

First Name _____ Last Name _____ Middle Initial ___ Male / Female
Date of Birth _____ Social Security # _____-_____-_____ Marital Status S __ M __ D __ W __
Street Address _____ City & ZIP _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer/School _____ Employment Status: full time / part time / temp / seasonal

Section III Healthcare Insurance Policy Information

Name of healthcare insurance company where policy is currently active _____
Have you called to verify benefits or to initiate authorization to access benefits? (Circle one) Yes No

I am providing Crossroads a copy of both sides of my most current healthcare insurance card. I understand that it is my responsibility to provide up to date information regarding my coverage in the event I receive a new card, the policy changes, or my healthcare insurance changes in any way. (initial here) _____

I consent for Crossroads Counseling Group to release any and all necessary clinical and personal information (via mail, fax, telephone or electronically) to the insurance company for the purpose of accessing insurance benefits to pay for professional services received at Crossroads. **I understand I am responsible for payment of services rendered even if my insurance does not pay Crossroads towards my account for any reason.**

_____
Client (or Guardian) Signature Date

_____
Financially Responsible Party Signature (if different from Client) Date

Section IV Medical History and Physician Information

Primary Physician _____ Psychiatrist Name _____
Practice Name _____ Practice Name _____
Address _____ Address _____
City/State/Zip _____ City/State/Zip _____
Phone _____ Phone _____

Client's current condition of health: Height _____ Weight _____ Change in weight in past year ____ more / less
General health: Excellent Good Fair Poor **Vision:** Excellent Good Fair Poor **Hearing:** Excellent Good Fair Poor
Comments:

Date of last physical / physician visit: _____ Name of Physician: _____

Current Medications: (including over-the counter medications that you take regularly versus "as needed")

Medication	Dosage & Frequency	Start Date	Name of MD	Purpose

Please list any **physical symptoms** you are currently experiencing (or have within past 6 months):

Please list any significant **medical conditions** you have ever experienced:

Please list any known **allergies**:

Please list any **surgeries** you have had:

Please list any **hospitalizations** you have experienced (general dates, lengths of stay and reasons):

Current **alcohol** usage (amount per week) _____
Current **tobacco** usage (amount per day or week) _____
Current **recreational substances** (substance/amount per day/week/month) _____

History of above substance usage _____
_____
_____

Have you ever taken **medication for psychiatric/behavioral** reasons? _____ Yes _____ No
If Yes, please list and explain (what, when, why and results):

I consent for Crossroads Counseling Group to contact the physician(s) listed above for the following purposes: to share clinical information regarding my initial sessions at Crossroads (including presenting problem, diagnostic / assessment information, and treatment goals); to receive clinical/medical information from the physician that may be helpful for successful treatment. (Please initial) _____ Yes _____ No

The information I have given today is correct to the best of my knowledge. I understand that it is my responsibility to inform my therapist of any changes in my medical status, insurance information, or contact information. As a parent or guardian of a minor client, I am consenting for the above named minor to receive treatment at Crossroads Counseling Group. I understand that I am responsible for the prompt payment of fees associated with this account.

_____ _____
Client (or Guardian) Signature Date Witness Date