Client Number: ______________________________ **Counselor:** ____

I. CLIENT INFORMATION

This information is for internal use only and is intended to establish a complete and confidential portfolio for each client. **Please print clearly** and provide all of the requested information on both sides of the form. Feel free to discuss any questions or concerns with your counselor by calling them directly or on our main line: 636-449-1250.

Name____SSN________________________________

Date of Birth _________________ Age________ Gender __________ Email____________________________

Address____

City____State___________Zip_____________

Home: ( )___________________ Work: ( )_____________________ Cell: ( )___________________

May we leave a voice mail message at: Home Yes No Work Yes No Cell Yes No

Employer__________________________________ Position_________________________ How long?________

Marital status: ___Single ___Married ___Divorced ___Separated ___Widowed How long? ___________

Do you attend church?_________ Name: __________________________________ Are you a member?_______

Pastor's name ____________________________________ Denomination ________________________________

Emergency Contact

____(____)_______________

Name Relationship Telephone

How did you hear about our center? ____

II. RESPONSIBLE FAMILY MEMBER INFORMATION (Leave blank if same as above)

Name____SSN_____________________________

Date of Birth _________________ Age________ Gender __________Email____________________________

Address____

City____State_________Zip____________

Home: ( )_________________ Work: ( )_________________ Cell: ( )_________________

May we leave a voice mail message at: Home Yes No Work Yes No Cell Yes No

Employer__________________________________ Position_________________________ How long?________

III. SPOUSE/DEPENDENT INFORMATION

Name	Age	M/F	Will Individual Attend Sessions?	Relation to Client
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	

IV. PAYMENT INFORMATION

I understand that I am responsible for the full payment of all fees and that payment (cash, check, or credit card) is expected at the time services are rendered. Payments will be given directly to the Wellspring Christian Counseling staff employee working with me.

NOTES:

- Appointments not cancelled 24 hours in advance will be charged the full rate. **Please initial here: ______**
- I understand that when a portion of my fees are to be paid by another party, I am ultimately responsible for full payment of fees. **Please initial here: _____**

V. DATA MANAGEMENT INFORMATION

I understand that the information on this form will be entered into an internal computer database.

I would like to receive a monthly statement to file with insurance or medical reimbursement company. **Yes No**

Please check this box if you ***do not*** wish to receive mailings from Wellspring Christian Counseling ☐

____

Signature of Client ***Date***

____

Signature of Responsible Family Member ***Date***

Rev. 11/13/08