Wellspring Center, PLLC
Counseling, Consulting &
Psychological Services
1995 NC Hwy 172 Suite B
Sneads Ferry, NC 28460
Phone: 910-308-7270
www.wellspringcenterllc.com

CLIENT INFORMATION

Client Name: _____ **DOB:** _____

Address: _____

City/State/Zip: _____ **Email:** _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Other: _____

Home Phone: _____ **Cell Phone:** _____ **Other:** _____

Referral Source: _____ **Phone:** _____

Relationship to Client: _____ **Organization:** _____

May we contact referral source to acknowledge referral? ☐Yes ☐No

Primary Care Physician: _____ **Phone:** _____

Reason for Referral: _____

- ☐ Depression
- ☐ Anxiety
- ☐ Trauma/ Abuse
- ☐ Behavior Disorder
- ☐ School Problems
- ☐ Work/ School Issues
- ☐ Marital Therapy
- ☐ Family Therapy
- ☐ Parenting Concerns
- ☐ Grief/ Loss
- ☐ Stress – Related
- ☐ Relationship Issue
- ☐ Other: _____

Symptoms:

☐ Depressed mood ☐ Sleep disturbance ☐ Appetite disturbance ☐ Agitation ☐ Panic attacks

☐ Low energy ☐ Elated/euphoric mood ☐ Agitation ☐ Anger/aggression ☐ Irritability ☐ General anxiety

☐ Hyperactivity ☐ Impulsivity ☐ Delusions ☐ Hallucinations ☐ Impaired judgment ☐ Psychosis

☐ Other: _____

When did problem(s) begin? _____

Goal(s) for treatment: _____

Suicidal Risk	Homicidal Risk	Domestic Violence	Abuse (□Victim □Perp)
□ None	□ None	□ None	□ None
□ Ideation	□ Ideation	□ Emotional/Psychological	□ Neglect
□ Intent	□ Intent	□ Physical Abuse	□ Emotional/Psych
□ Plan	□ Plan	□ Sexual	□ Physical Abuse
□ Means	□ Means	□ Prior History	□ Sexual
□ Prior attempts	□ Prior Attempts		

Comments: -

_____
_____
_____
_____

Substance Use/Abuse History (Onset, duration, frequency, amount, consequences, treatment):

_____
_____
_____
_____

Medical History:

Medications (list):_____
_____

Chronic Illnesses/conditions_____

Surgeries/Hospitalizations (include dates):_____
_____

Living Arrangements (List others residing in the home by name, relationship and age):_____
_____
_____
_____

Emergency Contact:

Name_____**Relationship**_____
Address_____
Home Phone:_____**Mobile**_____**Other**_____

Insurance Information:

Primary Policy:

Subscriber: _____ **DOB:** _____

Relationship of Subscriber to Client: _____

Employer: _____ **Phone:** _____

Service Branch (if military): _____ ☐ **Active duty** ☐ **Retired Rank:** _____

Insurance Company: _____ **Phone:** _____

Policy Number: _____ **Group ID:** _____ **Effective Date:** _____

Secondary Policy:

Subscriber: _____**DOB:**_____

Employer:_____ **Phone:**_____

Insurance Company:_____ **Phone:**_____

Policy Number: _____**Group ID:**_____ **Effective Date;**_____

Tertiary Policy: ☐ **No** ☐ **Yes (provide information as requested above):**_____

_____

_____

I authorize this office to release any information obtained during evaluations or treatment of this client to the insurance companies listed above which is necessary to expedite and support any insurance claims on this account. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize the payment of benefits otherwise payable to me directly to this provider.

Client/Parent/Guardian Signature:_____Date:_____

For Office Use Only

Appointment Scheduled _____ Clinician _____

Alicia L. Chinlund, MA, LCMHC, LPA
Psychologist & Licensed Clinical Mental Health Counselor
Certified Health Services Provider
achinlund@wellspringcenterllc.com