Premier Counseling Services, PLLC
2004 S ST Aubin Suite 101
Sioux City, IA 51106

Today's Date:_________________

PLEASE PRINT

1. Name: ____ Birth Date:__________________ Age:__________

Mailing Address:____

Street City State Zip

May we use the above address for billing & correspondence? Yes No

Phone (at which you may be reached):______________________May we leave a message? Yes No

Marital Status: Never married Now married (# times married_____) Separated Divorced Widowed

Sex: male female Social Security #:____

2. Do you have a legal guardian? Yes No Guardian's name: _______________________________________
address:____ phone:__________________________

3. In case of emergency, whom should we contact? ____
(Name) (Phone)

____

(Address) (Relationship of this person to you, e.g., parent, spouse, friend, etc.)

4. Primary insurance carrier's name & phone number?____

5. Insured's name & ID#?____Birth Date:_____________

6. Deductible & Co-pay information?____

7. Secondary insurance carrier's name & phone number?____

8. Insured's name & ID#?____Birth Date:_______________

9. Deductible & Co-pay information? ____

10. Primary physician's name & city:____

11. How did you learn about our practice?____

12. Are you employed: Yes No Not applicable If yes, how long at current position? ____________________

What type of job do you hold?

professional/technical manager/administration homemaker sales/service

clerical craftsperson farmer/farm manager laborer other

If unemployed, for how long?____
Primary reason for unemployed status?____

OVER

13. Have you received mental health care before? Yes No

If yes, approximately how many different therapists have you had (not the # of appointments)?_______
What were the approximate dates of earlier treatment(s)?________________________________
Have you ever been hospitalized for a mental health concern? Yes No
If yes, what approximate date(s) and what hospital(s)?_________________________________

14. Have you received substance abuse/dependency (drug and/or alcohol) services? Yes No

If yes, how many times?____
Ever received inpatient substance abuse treatment? Yes No
If yes, when and what facility(ies)?____

15. What illnesses/conditions do you have?

Asthma headaches thyroid seizures colon trouble pain ulcers cancer

diabetes high blood pressure Other:______________________________________

allergies, please list:____

16. What medications do you currently take?____
____

17. What surgeries have you had?____

18. Have you ever lost consciousness? Yes No If yes, for how long? __________ What was the cause of the unconsciousness?____

19. Which of the following best describes your alcohol consumption?

I don't drink alcohol. I drink ___________ drinks per week (on average).

20. Do you currently use any other non-prescribed mind altering substances (street drugs)? Yes No

If yes, please list:____

21. Have you used street drugs in the past? Yes No

If yes, please list:____

22. Have you ever thought about killing yourself? Yes No

If yes, when?____
If yes, did you have a plan(s)? Yes No
If yes, did you attempt your plan(s)? Yes No
If yes, how many attempts? ___________ When were these attempts?____________________________

23. What would you like to discuss during your appointment: ____
____
____

I understand and agree that I am responsible for the charges for services provided and any balance not paid by my insurance policy.

____
(Patient or guardian's signature)