Life Choices Professional Group, LLC

Date: ______________

Client Name:______________________________________
Address:____
City: _______________ Zip:________________________
Home #: ______________ Work#: ___________________
DOB: ____
SS#:____
Years of Education: _______________________________
Employer/School:___________________________________
Religion: ________________Active?___________________
Physician:____
Health Problems:___________________________________
Current Medications Taken:___________________________
____

Spouse/Parent: ____________________________________
Address: ____
City: _________________ Zip: ______________________
Home #: ______________ Work #: __________________
DOB: ____
SS#: ____
Years of Education: _________________________________
Employer/School: ___________________________________
Religion:_____________ Active?______________________
Physician: ____
Health Problems: ___________________________________
Medications Taken: __________________________________
____

Family Members' Names	Age	School/Employer:
______________________________	__________	_____________________________________
______________________________	__________	_____________________________________
______________________________	__________	_____________________________________

If a message needs to be left at your home number regarding your appointment, can the information be left on an answering machine or with another family member? ________YES ________NO

Reason for Previous Therapy or Treatment from a Psychologist or Psychiatrist (if any):
____

In Case of Emergency, notify (Name, Address, Phone): ____

Whom may we thank for your referral to the practice?:____
May we contact this person to let them know you made an appointment? _______YES _______NO

Insurance Co: __________________________________
Deductible Amount (if any): $_____________________
Copay Amount: $_______________________________

Claim Phone #: __________________________________
If deductible, has it been met? _______________________
ID/Policy #: ______________________________________

FOR OFFICE USE ONLY:

AUTHORIZATION#: ______________________

Axis I: ____
____

Axis II: _____________________________________ Axis III: ____

Axis IV: _____________________________________ GAF: _______________________

Mailer Sent _____

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