HERITAGE
Counseling and Wellness
PLLC

www.heritagecw.com
910.240.4599

Client Information Form

Please note that this information is confidential.
This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Name of person completing this form: _____

Relationship to the Client: _____

Today's date: _____/_____/_____

A. Identification
Full Name of Client: _____
Date of birth: _____/_____/_____
Age: _____
Gender: _____
Name you wish to be called: _____

Address: _____
City: _____ State: _____ Zip: _____

Email address: _____
May we use this e-mail address for communication with you? Yes No

Mobile phone: _____
May we leave a voice message? Yes No
May we send a text message? Yes No

Other phone: _____
May we leave a message? Yes No

Marital Status: (please circle): Single Married Separated Divorced Widowed
Other: _____

Employment Status (please circle): Employed Unemployed Retired Full-time Student Active Duty Military Reserves
Other:_____

B. Referral

How did you hear about our practice? Primary Care Provider Friend/Family Website
Other: _____

C. Your Education and Training

How many years of school have you had? High School AA/AS BA/BS Master's PhD/MD
Degrees/certificates:_____

Occupation: _____
Have you served in the military? Yes No

D. Billing and Insurance

Person Responsible for Billing: _____

Is the client covered under this insurance policy? Yes No

Is Heritage Counseling and Wellness, PLLC In-Network with this Insurance?
Yes No

Insurance company: _____
Phone:_____
Policy #: _____
Group #:_____
Name of insured (if other than yourself):_____
Address of insured (if other than yourself): _____

Is your Insurance Coverage funded fully or in part by the state of North Carolina?
Yes No

Relationship to client (circle one): Spouse Mother Father Step-Parent Guardian

Insured's date of birth: _____
Deductible: _____
Deductible met? Yes No
Co-pay: _____

E. Emergency Contact (required):

_____ Check if emergency contact is the same as "Person Responsible for Billing", otherwise please complete below:

Name: _____
Relationship to client: _____
Phones: Mobile (_____) _____ _____ Home (_____) _____ _____
Work (_____) _____ _____

F. Medical Information

Primary Care Provider (PCP): _____
Phone (_____) _____ _____ Fax (_____) _____ _____

Do you have any conditions and/or limitations being treated by a medical professional or psychiatrist? Yes No
If yes, please provide physician name:
_____
_____
_____

Please list all current medications:
_____
_____
_____

Previous hospitalizations (date/reason):
_____
_____

Chemical Use:
Do you smoke or chew tobacco? No Smoke Chew
# of packs per week : _____

Do you use vapor or e-cigarettes? No Yes
If yes, how often per week? _____
Do you drink alcohol? No Yes
How many drinks of beer, wine, or hard liquor do you consume in a typical week?
_____

Do you use any other substances? No Yes

Would you like me to contact any of your other health or mental health providers?
Yes* No *If yes, please fill out a Release of Information Form for each provider.

G. Mental Health and Social History

Household Members (other than self):
Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Name: _____ Age: _____
Relationship: _____

Are any members of your immediate family deceased? Yes No

Have you attended therapy previously, or are currently in treatment? Yes No
If yes, Name of Clinician Year and Length of Treatment
_____

Have you ever been diagnosed with a mental health condition? Yes No
If yes, what was the diagnosis? _____

Do you or does any family member suffer from alcoholism, addiction or mental disorders? Yes No
If yes, please explain:

_____
_____
_____

Have you/client ever experienced or witnessed a traumatic event(s)? Yes No
If yes, please explain:

_____
_____
_____

H. Current Problems or Difficulties

1. Please describe the main issues that led to your coming to seek therapy?:

_____
_____
_____
_____
_____

2. What are your goals for therapy?

_____
_____
_____
_____
_____

3. Do you have any particular concerns or fears regarding therapy?

_____
_____
_____
_____
_____

Please select all areas of concern for yourself/client:

_____Alcohol or Drug Use Alcohol or Drug use in family _____ Anger/Irritability
_____ Anxiety _____Childhood Abuse or Neglect _____Couples' concerns
_____Depression _____Difficulty Making Decisions _____ Divorce/Remarriage
_____Domestic Violence _____Eating Problems _____Excessive Worry
_____Finances _____Gambling _____Feelings of Guilt _____Grief/Loss
_____Hopelessness _____Hyperactivity _____Impaired Memory
_____Isolation/Withdrawl _____Job Issues _____Less Interest or Pleasure in Things
_____Major Life Change _____Mood Changes _____Muscle Tension
_____Menopause _____Nightmares/Night-terrors _____Obsessive Behaviors
_____ Pain _____Panic _____Parent/Child Conflict _____Poor Concentration
_____Stress _____Sexual Problems _____Self Esteem _____Sexual Assault/Rape
_____School Failure _____Sleeping Problems _____Thoughts of Suicide/Death
_____Thoughts of Homicide _____Weight Loss/Gain _____Cutting or other self-harm

Other:
_____
_____

H. Other Information

1. Would you list some of your strengths or accomplishments that are important to you?

_____
_____
_____

2. Would you list some of the coping skills that you currently use to manage stress?

_____
_____
_____

3. Are you/client currently involved in any litigation? Yes No
If yes, please explain: _____

4. Do you feel that you have social/family support? Yes No

Thank you for taking the time to complete this form. When we meet, please feel free to ask any questions about this form, or to tell me anything else that you would like me to know.

By signing, I agree the above information is true, to the best of my knowledge.

_____
CLIENT/GUARDIAN'S SIGNATURE DATE