NANCY K. VERMEERCSH, LCSW

Client Information Sheet

(Please Print)

Client Name: _____ Date: _____

Address: _____ DOB: _____

City: _____ Home Phone: _____

State/Zip: _____ Work Phone: _____

Email: _____ Text: _____

***Do you give me permission to use email or text if necessary to reach you:** yes: ____ no: ____ initial: _____

(If under age 18) Parent/Guardian Name: _____

Parent/Guardian Phone: _____

PRIMARY HEALTH INSURANCE

Insured Name: _____

Insurance Co: _____

Address: _____

_____

Policy #: _____

Group #: _____

SECONDARY HEALTH INSURANCE

Insured Name: _____

Insurance Co: _____

_____

Policy #: _____

Group #: _____

Your Relationship Status: _____

Education Level: _____

Current Employer: _____

Job Title: _____

Medical/Psychological History:

Current Medical Problems/Concerns: _____

_____

List Current Medications: _____

_____

(See Back of Page)

Do you have any digestive problems? _____. Have you ever had any brain injury, or concussions?

_____

Please describe any current or history of drug use: _____

_____

Please describe any current or history of alcohol use: _____

_____

Any history of abuse (physical, sexual, emotional):_____

_____

Have you ever attempted suicide? _____

_____

Please describe any recent or current thoughts of suicide:_____

_____

Please describe any thoughts of hurting others: _____

_____

Please describe any violence against others: _____

_____

Please give a description of the reason you are seeking counseling:_____

_____

_____

_____

_____

Do you have a religious preference?_____

In what ways do you want to include spirituality in our counseling sessions?_____

_____

_____

_____

_____