Eagle Creek Counseling Client Information

Patient Name: _____ D.O.B. _____ Sex ____
Last I. First

Address: _____ City _____ State _____ Zip Code _____

Where can we call you? ☐Cell_____ ☐Home_____ ☐Work_____

Email address: (for electronic reminders) _____

Address to which we can send mail:_____

Emergency contact: _____ Relationship to you: _____ Phone: _____

Status (Please check all that apply)

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Occupation: _____ Employer: _____ Education level: _____

How did you hear about us?

☐ Eagle Creek Counseling Website
☐ Client of Eagle Creek
☐ Insurance Co.
☐ Doctor/Counselor (name) _____
☐ Church (name) _____
☐ Other _____

Please describe why you are here today. _____

_____

Symptoms (check any that apply)

☐ Anxiety
☐ Nervousness
☐ Palpitations
☐ Severe Stress
☐ Panic Attacks
☐ Excessive Worry
☐ Other_____

☐ Depression
☐ Sleep changes
☐ Weight loss/gain
☐ Appetite changes
☐ Problems concentrating
☐ Personality changes

☐ Thoughts of suicide
☐ Mood swings
☐ Memory lapses
☐ Sexual problems
☐ Addiction problems
☐ Alcohol concerns

☐ Low self-esteem
☐ Impulsive behavior
☐ Relationship problems
☐ Parent/child problems
☐ Work related problems
☐ Financial problems

You acknowledge the following with your signature:

- I have received a copy of the Notice of Privacy Practices.
- I have read and agree to the payment/cancellation policy.
- I have read the Consent for Treatment and wish to be seen at Eagle Creek Counseling Services.

Signature:_____ Date:_____

Your name (print please) if client is a minor: _____

Print