Basic Mindfulness Portland, LLC

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CLIENT INFORMATION FORM

Today's date ________________ Referred by ____

Last Name _________________________________ First Name __________________________ M.I. __________

Home phone (_____) ____________Cell phone (_____) ____________Work phone (_____) ________________________
(Okay to call you at work? Yes | No)

E-mail ____

Home Address ____

City ____State ____________ Zip _______________________

Street Address (if different)____

City ____State ____________ Zip _________________________________

Sex ___M ___F Date of Birth _____/_____/_____ Age ______ SS# _________ /_________ /_______________________

Employer/School____

Street Address ____

City ____State ____________ Zip _________________________________

EMERGENCY CONTACT

Person to contact in case of emergency ____

Telephone (_____) _________________ Relationship to you ____

BILLING | INSURANCE

Name of person responsible for payment _________________________Relationship to client ______________________

Address _______________________________________City ________________ State____ Zip ____________________

Primary Insurance

Name of Insurance Company (*please provide copy of card)* ____

Policy (ID) Number _____________________________Policy Group Number __________________________________

Address ____

City ____________________________State _______Zip _____________Telephone______________________________

Policy Holder's Name (*Last, first, middle*) ____

Address ____

City ____________________________State _______Zip _____________Telephone______________________________

Policy Holder's Date of Birth _____/_____/_____ Policy Holder's SS#_________ /_________ / ____________________

Client's Relationship to Policy Holder (*check one*): Self [ ] Spouse [ ] Child [ ] Other [ ]

Secondary Insurance

Name of Insurance Company (*please provide copy of card)* ____

Policy (ID) Number _____________________________Policy Group Number __________________________________

Address ____

City ____________________________State _______Zip _____________Telephone______________________________

Policy Holder's Name (*Last, first, middle*) ____

Policy Holder's Date of Birth _____/_____/_____ Policy Holder's SS#_________ /_________ / ____________________

Client's Relationship to Policy Holder (*check one*): Self [ ] Spouse [ ] Child [ ] Other [ ]

For Office Use:

Briefly, what concerns have brought you here and what are your goals for this visit?

____

____

____

Have you ever consulted with a mental health professional or received counseling services? Yes [ ] No [ ]
If yes, when and with whom?

____

Please check any concerns below which are related to your seeking today's consultation:

_____ school/learning problems
_____ anxieties panic attack, fears
_____ I am a survivor of abuse/family dysfunction
_____ impulse to hurt, injure, or cut self
_____ relationship with family/parents/siblings
_____ child's behavior
_____ low self-esteem
_____ alcohol/other drugs
_____ depression, feeling sad or down
_____ irritability /anger/hostility
_____ financial concerns
_____ career concerns
_____ death/impending death of a significant person
_____ I have experienced a traumatic event
_____ issues relating to sexuality
_____ eating concerns
_____ parenting concerns
_____ couples concerns
_____ break up/loss of relationship
_____ impulse to hurt others/destroy things
_____ suicidal thoughts/feelings
_____ other (please specify):

____

MEDICAL INFORMATION

Personal Physician ____

Current Medications ____

Drug Allergies ____

Major Medical Problems/Surgeries____

FAMILY HISTORY AND MEDICAL INFORMATION

Please list the members of your family and their health status & any major illnesses, including psychological.
(*If deceased, please include the age at death and cause*)

Name **Age** **Occupation** **State of Health**

Mother(s)____

Father(s) ____

Sister (s) ____

Brother (s) ____

Spouse ____

Children____

Other ____