CONSCIOUS CHOICES

Conscious Choices
Client Information Form

Today's date: _____

CLIENT INFORMATION

Client's last name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (circle one) Single /Mar /Div /Sep /Wid		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F	
Street address:		Social Security no.:	Home phone no.: ( )			
P.O. Box:	City:	State:	ZIP Code:			
Client's Occupation:	Employer:	Employer phone no.: ( )				
Spouse's Occupation:	Employer:	Employer phone no.: ( )				
Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital			
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Other family members seen here:						

FAMILY MEMBERS

(Please list your mother, father, and children.)

Name	Birth Date	Address (if different)	Home phone no.	Role
	/ /		( )	Mother
	/ /		( )	Father
	/ /		( )	
	/ /		( )	
	/ /		( )	
	/ /		( )	
	/ /		( )	

120 CORN PLANTERS STREET, CHARLESTON, SC 29492
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CONTACT INFORMATION

(Please tell us how we may contact you)

Place	Phone Number	Okay to Call	Okay to Leave Message
Home	( )	☐	☐
Work	( )	☐	☐
Cell	( )	☐	☐
Family Medical Doctors		☐	☐
		☐	☐

Email Address: ☐ Okay to send info about classes & worshops

FAMILY HISTORY

History of Pregnancies

Is anyone currently preganant? ☐ Yes ☐ No	What Trimester?	Who?
Prior pregnancy? ☐ Yes ☐ No	Miscarriages? ☐ Yes ☐ No	Abortions? ☐ Yes ☐ No

Marital History

Are you currently?
☐ Married ☐ Divorced ☐ Separated ☐ Engaged
☐ Living Together

How long have you been this way?

Do you have a history of affairs?
☐ Currently ☐ In the past

Ethnicity:

Religious/Spiritual History:

Educational Level (Highest degree earned for each family member):

Any history of substance abuse in current or past generations? If so, please describe who, what, and when in this space.
☐ Yes ☐ No

Any history of criminal convictions in current or past generations? If so, please describe who, what, and when in this space.
☐ Yes ☐ No

Any history of trauma? If so, please describe who, what, and when in this space.
☐ Yes ☐ No

Any history of sleeping problems? If so, please describe who, what, and when in this space.
☐ Yes ☐ No

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Any history of eating problems? If so, please describe who, what, and when in this space.

☐ Yes ☐ No

Any previous therapy? If so, please tell us who the therapist was, who went, when they went, and how long they went.

☐ Yes ☐ No

Who	Medication	Dose

CANCELATION POLICY

I UNDERSTAND THAT WHEN I BOOK A SESSION, THIS TIME IS RESERVED EXCLUSIVELY FOR ME. I AGREE TO GIVE AT LEAST 2 BUSINESS DAYS NOTICE IF I NEED TO RESCHEDULE OR CANCEL A SESSION. IF I GIVE LESS THAN 2 BUSINESS DAYS NOTICE, I AGREE TO PAY FOR THE MISSED SESSION.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible the day of the session unless other arrangements are made in advance. I also authorize Conscious Choices to charge my credit card if I do not pay the balance.

_____ _____

Patient/Guardian signature Date

_____ _____

Patient/Guardian signature Date

_____ _____

Patient/Guardian signature Date

_____ _____

Therapist signature Date

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