



Conscious Choices Client Information Form

Today's date: _____

CLIENT INFORMATION					
Client's last name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (circle one)
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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
	/ /		()	
	/ /		()	
	/ /		()	
	/ /		()	
	/ /		()	

8000 BONHOMME AVE, SUITE 413, CLAYTON, MO, 63105

WWW.CONSCIOUSCHOICES.COM | (828) 329-0431 | ROBERTA@CONSCIOUSCHOICES.COM



CONTACT INFORMATION

(Please tell us how we may contact you)

Place	Phone Number	Okay to Call	Okay to Leave Message
Home	()	<input type="checkbox"/>	<input type="checkbox"/>
Work	()	<input type="checkbox"/>	<input type="checkbox"/>
Cell	()	<input type="checkbox"/>	<input type="checkbox"/>
Family Medical Doctors		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
Email Address:		<input type="checkbox"/> Okay to send info about classes & workshops	

FAMILY HISTORY

History of Pregnancies			Marital History	
Is anyone currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	What Trimester?	Who?	Are you currently? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Engaged <input type="checkbox"/> Living Together	
Prior pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Abortions? <input type="checkbox"/> Yes <input type="checkbox"/> No	How long have you been this way?	Do you have a history of affairs? <input type="checkbox"/> Currently <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Any history of criminal convictions in current or past generations? If so, please describe who, what, and when in this space. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Any history of trauma? If so, please describe who, what, and when in this space. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Any history of sleeping problems? If so, please describe who, what, and when in this space. <input type="checkbox"/> Yes <input type="checkbox"/> 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.: ()
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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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