



**CLIENT PROFILE FORM**

**Patient Information**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Other Phone Work/Cell#: \_\_\_\_\_

Is it okay to contact you at the numbers listed above: Yes or No, if not best contact number (s) for you:

\_\_\_\_\_

Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Martial Status: \_\_\_\_\_

**Emergency Contact**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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**Person Responsible for Payment**

Responsible Party is Patient: Yes No

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Other Phone Work/Cell#: \_\_\_\_\_

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**Financial/Policy Holder Information**

Primary Insurance:

Insurance Company: \_\_\_\_\_ Contract#: \_\_\_\_\_ Group#: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder Address if Different from Patient: \_\_\_\_\_

Policy Holder Phone Number: \_\_\_\_\_ Sex: Male or Female

Secondary Insurance: Yes No

Insurance Company: \_\_\_\_\_ Contract#: \_\_\_\_\_ Group#: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder Address if Different from Patient: \_\_\_\_\_

Policy Holder Phone Number: \_\_\_\_\_ Sex: Male or Female

**Authorization to Release Information**

The undersigned authorizes **Magee Madry Counseling Services, LLC** and its associates providing services to release medical or other relevant information about the patient which may be used as necessary in the completion of insurance claims, review of received services and receipt of benefits. The undersigned understands that the information released may include and is not limited to sensitive information related to mental health. The information may be released to third-party payer (s) including the third-party payer (s) agent and/or representative or anyone responsible for payment of received services.

**Assignment of Benefits**

The undersigned assigns and authorizes direct payment of benefits including insurance benefits, otherwise payable with respect to the patient to **Magee Madry Counseling Services, LLC**. By request the undersigned agrees to assist in the processing of claims for benefits.

I acknowledged that I have read the form and understand its purpose and content.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**CLIENT INTAKE FORM**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

List any previous marriages and length of marriage(s) if applicable: \_\_\_\_\_  
\_\_\_\_\_

If you have children how many and their ages: \_\_\_\_\_  
\_\_\_\_\_

How did you learn about Magee Madry Counseling Services? \_\_\_\_\_  
\_\_\_\_\_

Reason for seeking treatment/what issue brings you to Magee Madry Counseling Services? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has the problem(s) that brings you to treatment been an issue? \_\_\_\_\_  
\_\_\_\_\_

What is your goal for treatment/what do you seek to achieve from treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What if anything has been helpful for you in coping and dealing with the problem you described?  
\_\_\_\_\_  
\_\_\_\_\_

Have you previously been in counseling: Yes or No, if yes was it helpful? \_\_\_\_\_

Current prescribed medications taking, include any over the counter medications: \_\_\_\_\_

Have you ever been prescribed medication for a psychological disorder: Yes or No, if yes please list medication(s) \_\_\_\_\_

Have you ever had any inpatient hospitalizations for psychiatric treatment: \_\_\_\_\_

**Please check all of the items below that describe your situation:**

- Abuse/trauma – physical, sexual, emotional, neglect
  - Alcohol use
  - Anger, hostility, arguing, irritability Anxiety, nervousness
  - Attention, concentration, distractibility
  - Career concerns, goals, and choices
  - Childhood issues
  - Codependence
  - Confusion
  - Compulsions and/or obsessions (thoughts or actions that repeat themselves)
  - Decision-making, indecision, mixed feelings, putting off decisions
  - Delusions (false ideas)
  - Dependence
  - Depression, low mood, sadness, crying
  - Divorce, separation, marital conflict, infidelity/affairs
  - Drug use – prescription medications, over-the-counter medications, street drug
- Fatigue, tiredness, low energy
  - Fears, phobias
  - Financial or money troubles, debt, impulsive spending, low income
  - Grieving, mourning, deaths, losses, divorce
  - Guilt

- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Impulsiveness, loss of control, outbursts
- Legal matters, charges, suits (past and present)
- Loneliness
- Memory problems
- Mood swings
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, lack of motivation
- Relationships problems (with friends, with relatives, or at work)
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, identity issues
- Sleep problems (too much, too little, insomnia, nightmares)
- Spiritual, religious, moral, ethical issues
- Stress and tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment issues

**Family History:** If there is a family history of any of the following, if so please indicate the relationship of the family member to you (mother, father, sister, etc.) in the blank provided.

Alcohol Abuse Yes or No \_\_\_\_\_

Child Abuse i.e. physical, emotional, sexual Yes or No \_\_\_\_\_

Substance Abuse Yes or No \_\_\_\_\_

Bi-Polar Disorder Yes or No \_\_\_\_\_

Anxiety Disorder Yes or No \_\_\_\_\_

Depression Yes or No \_\_\_\_\_

Suicide Attempts Yes or No\_\_\_\_\_

Schizophrenia Yes or No\_\_\_\_\_

Domestic Violence Yes or No\_\_\_\_\_

Divorce or Martial Problems Yes or No\_\_\_\_\_

Additional Comments\_\_\_\_\_

**Religious and/or Spiritual Information:**

*Religion/Spiritual Affiliation is an important dimension of some clients lives and it is important that their religious/spiritual beliefs are a part of the therapy process. For other clients they may have had past negative experiences related to religion or their faith life. For some clients religion, spiritual affiliation and/or faith are unimportant and have no place in the therapy process. Please answer the questions below, so that Magee Madry Counseling Services may serve you in the most helpful manner and respect your religious/spiritual affiliation (if any):*

Is religion an important part of your life? Yes or No, if yes are you affiliated with a specific denomination i.e. Non-denominational, Baptist, Catholic\_\_\_\_\_

Do you believe in God, or do you define yourself as Spiritual or believing in Divine Intervention?\_\_\_\_\_

Do you pray or meditate? Yes or No, if yes is pray or meditation a part of your daily routine?\_\_\_\_\_

*The ideology of Magee Madry Counseling Services, LLC is, each individual has a personal journey and while on their personal journey of growth and transformation they have the ability to positively effect the lives of others. Thank you for entrusting Magee Madry Counseling Services, LLC to journey with you.*