Cynthia J. Swanson, M.A., LPCC Today's Date:_____

WELCOME TO MY OFFICE *Thank you for choosing my services.*

In order for me to serve you properly I will need the following information. This is, of course, completely confidential.

Name | Birthdate | Social Security No.

Address | City | State | Zip | Home Phone

If child, parent's or guardian's name | Parent's Birthdate | Social Security No.

Name of employer | Address | Business Phone

Occupation | Marital Status

Name of spouse | Birthdate | Social Security No.

Name and address of spouse's employer | Business Phone

INSURANCE INFORMATION

Do you have mental health coverage:

_____ Yes _____ NO

If not, how do you intend to pay:

_____ Check _____ Cash

Insurance company name and address

Subscriber name: Member ID:

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am

| responsible for all charges, regardless of insurance coverage.

Signature: Date:

I _____ authorize/_____ do not authorize release of information to my physician.

Name of physician | Phone No.

Address of physician

HEALTH INFORMATION:

Date of last physical: _____

Health problems (major illnesses or conditions in past year and/or chronic conditions):

_____

_____

Medications (if any) and reason for taking:

_____

_____

Please rate the amount of concern your problem is causing in each of the following area by placing an X in the column that most closely describes it:

	No Concern	Some Concern	Moderate Concern	Serious	Very Serious
Ability to sleep	○	○	○	○	○
Appetite	○	○	○	○	○
Ability to work	○	○	○	○	○
Relationships	○	○	○	○	○
Ability to concentrate	○	○	○	○	○
Depression	○	○	○	○	○
Thoughts of suicide	○	○	○	○	○
Physical health	○	○	○	○	○
Your memory	○	○	○	○	○
Alcohol/drug concerns	○	○	○	○	○
Anxiety	○	○	○	○	○

Have you had previous counseling? If so, when, how long and for what concern:

_____

_____

What specific event or experience has led you to seek counseling now:

_____

_____