

Lighthouse Counseling Center, P.C.

Adult Client Questionnaire
(18 years and older) Rev. 10/09

This information will help your therapist understand you better. This, as well as other communications with your therapist will be kept confidential to the full extent of Georgia law.

Proof of insurance coverage & ID is required.

Background information:

Today's Date: _____

Name of Client: _____ Age _____ DOB: _____ M / F

Residing Address: _____ City _____ State: ____ Zip _____

Mailing Address _____ City _____ State: ____ Zip _____

Home Telephone _____ Cell/Work/ other _____

Contact number for messages from our office: _____
(WE ARE NOT RESPONSIBLE FOR CONFIRMING APPOINTMENTS WITH YOU.)

ER Contact Name: _____ Tel #: _____ Relation: _____

Referral Source: _____ May we send a thank you? Y / N

Marital Status: Single / Married / Separated / Divorced / Engaged /Widowed

Insurance Information:

PRIMARY

SECONDARY

PLEASE PRINT. COPY OF CARD IS REQUIRED

Insurance Company _____ / _____

Policy Holder's Name _____ / _____

Relationship to Client _____ / _____

ID Number _____ / _____

SS # _____ / _____

Employer _____ / _____

Employer Telephone Number: _____ / _____

CONTINUED ON BACK ▼

Immediate Family Members : Name(s) Age(s) ✓ if lives w/client

Spouse _____

Father: _____

Mother: _____

Children: _____ / _____

_____ / _____

_____ / _____

Others living w/client _____ Relationship _____

_____ Relationship _____

In your own words, briefly describe the main problem, which prompted you to seek counseling at this time _____

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place two checks by those items, which are most important.

- | | |
|--|--------------------------------|
| _____ Anger/Temper | _____ Sexual Concerns |
| _____ Depression | _____ Thoughts of Suicide |
| _____ Educational/School work | _____ Unhappy most of the time |
| _____ Family Problems | _____ Use of Alcohol |
| _____ Fearfulness/Phobias | _____ Use of Tobacco |
| _____ Insecure/Timid/Lack of Self Confidence | _____ Excessive caffeine |
| _____ Marital Problems | _____ Work |
| _____ Divorce | _____ Worry |
| _____ Financial | _____ Stress |
| _____ Traumatic Stress | |
| _____ Physical | |
| _____ Religious/Spiritual Concerns | |
| _____ Other (Specify) _____ | |

_____ Current substance use: _____ Marijuana, _____ Narcotics _____ Amphetamines
_____ Methamphetamines _____ Cocaine _____ Hallucinogens _____ Acid _____ Prescription
_____ Alcohol _____ Cigarettes _____. If checked, frequency of use: _____

Is there anything else, which you believe might be important for your therapist to know about you: _____

Have you ever been a victim of or witnessed any type of traumatic incident? If yes, please explain: _____

Medical History (Please use back of page if necessary)

Has there been any previous counseling or psychological, psychiatric, neurological, or EEG evaluations? _____ If so, please list names, addresses, and dates of contact.

Current Medications: _____

Describe your appetite and eating habits _____

Describe your sleeping pattern now. Are there nightmares or night terrors now or in the past? _____

Describe your level of activity _____

Food or drug allergies? _____

Primary Care Physician: or other health care provider name: _____

Address: _____ Telephone: _____

I authorize Lighthouse Counseling Center PC to administer counseling and psychological treatment. **Proper ID and proof of insurance will be provided upon request by Lighthouse Counseling Center**

Signed _____
Client

Print Name: _____ Date: _____