Carolina Center for Counseling & Behavioral Interventions, LLC

421 SE Main Street , Suite 201 Simpsonville, South Carolina 29681 Phone: 864-963-4028

Client Name _____ Gender ☐ M ☐ F
Last First Middle

Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work Phone _____

E-mail Address _____

Preferred contact number ☐ Home ☐ Cell ☐ Work

Reason for Visit _____

Referral Source _____

Any legal involvement, if so please explain _____

Any state agency involvement (DSS, DJJ, DDSN, etc), if so please explain _____

Responsible party if different from above _____ relationship _____

SS# for Responsible Party _____

Emergency Contact

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Employer (or Parent's if under 18) _____

Address _____ City _____ State _____ Zip _____

Phone number _____

Insurance Information

Insurance Company _____

Primary Insured's Name _____ Date of Birth _____

Primary Insured's Address _____

Policy Number _____ Group Number _____

Policy Holder's SS# _____ Contact Number _____

Secondary Insurance

Insurance Company _____

Primary Insured's Name _____ Date of Birth _____

Primary Insured's Address _____

Policy Number _____ Group Number

Policy Holder's SS# _____ Contact Number _____

Health Care Providers (currently receiving care or seen within the last year)

Family Physician _____ Phone _____

date of last physical _____

Psychiatrist _____ Phone _____

Other _____ Phone _____

_____ Phone _____

_____ Phone _____

Current Medications

Please list all of the medications you are taking. Include over the counter medications, herbs, & vitamins

Medication Name	Dose	Last taken	First taken

Medical History

Please check if you have ever been diagnosed or received treatment for any of the following:

- ☐ Anorexia or bulimia
- ☐ Anxiety disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Personality Disorder
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Stroke or Cerebrovascular Accident

Please describe any of your current health problems, chronic health conditions or allergies.

_____

_____

_____

Please check any of the following symptoms you have experienced within the last 6 months

- ☐ Weight loss or gain
- ☐ Sadness lasting for days or weeks
- ☐ Difficulty falling asleep, staying asleep
- ☐ Hearing voices
- ☐ Thoughts of hurting others
- ☐ Thoughts of hurting yourself
- ☐ Hallucinations
- ☐ Fear of people, places, or things

Have you ever been involved in treatment before? ☐ Yes ☐ No

If so please describe _____

_____

Have you ever been hospitalized or participated in residential treatment for emotional, behavioral, or mental health concerns. If yes, please describe. ☐ Yes ☐ No

_____

Family History: Describe all medical conditions in your immediate family

_____

_____

_____

_____

_____

_____