Crystal Favre, LPC

www.CrystalFavreLPC.com
470-295-5682

CLIENT INFORMATION

COMPLETION OF THIS FORM IS VOLUNTARY. YOU MAY OMIT ANY PARTS YOU WISH.

NAME_____

ADDRESS_____

_____

WORK PHONE_____

HOME PHONE_____

CELL PHONE_____

TEXT NUMBER_____

IF NECESSARY, MAY I CALL YOU AT WORK? YES NO
ANY SPECIAL INSTRUCTIONS?_____

IF NECESSARY, MAY I CALL YOU AT HOME? YES NO
ANY SPECIAL INSTRUCTIONS?_____

IF NECESSARY, MAY I CALL YOUR CELL PHONE: YES NO
ANY SPECIAL INSTRUCTIONS?_____

IF NECESSARY, MAY I TEXT YOU? YES NO

IF NECESSARY, MAY I E-MAIL YOU? YES NO

E-MAIL ADDRESS_____

ANY SPECIAL INSTRUCTIONS?_____

MAY I MAIL TO YOU? YES NO
ANY SPECIAL INSTRUCTIONS?_____

AGE AND DATE OF BIRTH:_____

OCCUPATION:_____

RELATIONSHIP STATUS: MARRIED SINGLE LIFE PARTNER DIVORCED

(Circle all that apply) SEPARATED WIDOWED INVOLVED DATING

SIGNIFICANT OTHER'S NAME, AGE, AND ANY RELEVANT INFORMATION ABOUT HER/HIM:_____

_____

_____

PLEASE LIST FAMILY MEMBERS' NAMES, AGES, AND ANY RELEVANT INFORMATION:

*MOTHER:

*FATHER:

*SISTERS:

*BROTHERS:

*CHILDREN:

*ANY OTHER IMPORTANT FAMILY MEMBERS (AUNTS, UNCLES, STEP-FAMILY MEMBERS)

HAVE YOU SEEN A COUNSELOR BEFORE? YES NO
IF YES, PLEASE INDICATE WHO, WHEN, WHERE, AND WHY:_____

_____

_____

PLEASE LIST ALL MEDICAL DIAGNOSES/CONDITIONS THAT YOU HAVE:

_____

_____

PLEASE LIST ALL MEDICATIONS, BOTH PRESCRIPTION AND OVER THE COUNTER, THAT YOU CURRENTLY TAKE, DOSAGE, AND REASON FOR TAKING:

_____

_____

NAME OF PRESCRIBING PHYSICIAN:_____

NAME OF FAMILY PHYSICIAN:_____

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC REASON? YES NO
IF YES, PLEASE INDICATE WHEN, WHERE, HOW LONG, AND FOR WHAT REASON.

_____

_____

_____

*PLEASE INDICATE WHO SHOULD BE CONTACTED IN CASE OF AN EMERGENCY:
(names and phone numbers)

_____

_____

*completion of this section indicates permission to contact these people should an emergency (as determined by the therapist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.

*I, _____, give my permission to Crystal Favre, LPC, to release information, only as requested by the insurance company and its representatives, to my insurance company and its representatives. If I have asked her to prepare a "superbill" for the purpose of my attempt to have my insurance company reimburse me and I have submitted said "superbill", I realize that my insurance company may contact her with a need for additional information in order to process my claim. My signature below indicates she has my permission to speak with my insurance company and its representatives about issues/questions related to my claim. I agree to no expiration date regarding this permission.

Signature: _____ Date:_____