

Eveline Briedwell, LCSW
Independent Contractor

East Cascade Counseling Services
Client Information Form

Today's Date: _____ Email: _____

A. Identification

Client Name: _____ Date of Birth: _____ Age: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
If client is a minor, Parent/Guardian: _____

B. Referral: Who gave you my name?

Name: _____ Phone: _____
Address: _____
May I have your permission to thank this person for the referral? Yes No

C. Medical Care: From whom or where do you get your medical care?

Doctor's name: _____ Phone: _____
Address: _____
Date of last physical (estimated): _____ Reason for visit: _____
Any medical conditions that you would like us to be aware of: _____
If you enter treatment with East Cascade Counseling Services, may we have your permission to consult with your medical doctor so that he/she can be fully informed and we can coordinate your treatment? Yes No

D. Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____
Address: _____

E. Current Employment or Not currently employed

Employer: _____ Address: _____

F. Insurance

Primary Insurance: _____ Phone: _____
Address: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____ Social Security: _____
Secondary Insurance: _____ Phone: _____
Address: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____ Social Security: _____

G. Other helpful information

Previous counseling, psychological services, alcohol/drug treatment? Yes No If yes, when and for what reason: _____
How was your previous counseling experience? _____
Brief description of your reason for today's visit: _____

I authorize payment of mental health benefits to Eveline Briedwell, LCSW. I also authorize the release of any mental health information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

Client/Guardian Signature: _____ Date: _____