

CLIENT INFORMATION SHEET

Charlotte Therapy Associates

Diane Yee, MS, LPC
5200 Park Rd, Suite 219
Charlotte, NC 28209

Important information in order for me to work with you:

NAME(1): _____

NAME(2): _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

BILLING

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE 1: DAY

(_____) _____ EVE(_____) _____

PHONE 2: DAY

(_____) _____ EVE(_____) _____

E-MAIL 1: _____

E-MAIL 2: _____

DATE OF BIRTH: (1) _____ (2) _____

Instructions regarding contacting you concerning scheduling and other matters:

PHONE NUMBER, IF ANY, WHERE WE ARE AUTHORIZED TO LEAVE A
MESSAGE IDENTIFYING THERAPIST'S NAME AND NUMBER:

HOME _____ WORK _____ CELL _____

Referral Information:

Referral Source:

Name Agency Telephone #

Referred To: _____

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A CONTACT PERSON IN CASE OF EMERGENCY:

NAME: _____ Relationship _____

DAY(_____) _____ EVE (_____) _____

Insurance Information:

WILL YOU BE USING YOUR INSURANCE? YES ___ NO ___ INSURANCE COMPANY: _____

MEMBER ID NUMBER: _____ NAME OF INSURED: _____

DOB OF INSURED: _____ INSURANCE PHONE #: _____

Are you or any family members in therapy now? YES ___ OR NO ___

Previously? If so, when, with whom, and for what reasons?

DO YOU WANT THE THERAPIST TO TALK WITH A PREVIOUS THERAPIST(S)?

IF YES: GIVE ADDRESS: _____

& PHONE NUMBER: _____

SIGNATURE For Consent: _____

DATE: _____

LENGTH OF PERMISSION: _____

SIGNATURE For Consent: _____ DATE: _____

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- Family Information: Start with all family members, and nonmembers, who live in the household and then include those outside the household that may also participate in the therapy.

Family/Other Members:	Ages:	Relationship To client:	√Members here today

- Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

- Are you or any family members taking prescribed medications? What are they and what are they being taken for?

- Are any of those who will be coming for therapy involved in divorce proceedings? If so, who has sole custody or is there joint custody of the minor children?

- Are you, or is anyone else in your family, experiencing thoughts of harming oneself or someone else?

- Have you or anyone in your family experienced instances of physical violence now or in the past?

- Have you had problems with a natural disasters (i.e., flood, hurricane) or another traumatic event?

- Do you have any special needs regarding therapy, such as a physical disability?