MONARCH
COUNSELING

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE: _____May we contact you at the #'s listed? YES/NO

EMAIL: _____

SOCIAL SECURITY #: _____D.O.B_____AGE: _____ Please Circle: MALE/FEMALE

HOW DID YOU HEAR ABOUT US: _____

OCCUPATION/POSITION: _____EMPLOYER NAME: _____

MARITAL STATUS: _____ SPOUSE NAME: _____DOB: _____

EMERGENCY CONTACT PHONE # and NAME: _____

HEALTH INSURANCE: _____ **ID#:** _____

NAME of PRIMARY INSURED: _____PRIMARY INSURED DOB: _____

SELF PAY: YES/NO, EAP: YES/NO If **Yes**, please provide the *Name and Address of the Company to BILL:*

_____ AUTH#: _____ # OF VISTS:_____

PRESENTING ISSUE:

_____

_____

MEDICAL DOCTOR(S): _____ PHONE(S): _____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/PSYCHIATRIC HOSPITALIZATION:

1. Therapist: _____ Phone: _____ Dates: _____ to_____

2. Therapist: _____ Phone: _____ Dates: _____ to_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

_____

Use the space on the back of this form if you need to give further information.