Eunice Lehmacher
Licensed Master Social Worker—Clinical Practice

Client Information

*Client's **Name**:*		***Date of Birth**:*
Parent/Guardian's Name (if client is a minor):		
*Mailing **Address**:*	*Email Address:*	
City:	*State:*	*Zip:*
Where you actually live (if different from above):		
City:	*State:*	*Zip:*
Please complete insurance information if employed and/or will be using health insurance.		
Insured Name & Address (if different from above):		*Insured Date of Birth:*
Employer:		*SSN:*
Insurance Company:	*Secondary Insurance Company:*	
Primary Physician:	*Phone Primary Physician:*	
Emergency Contact Information** (only use for emergencies)**:		*Relationship to client:*
Name:		*Phone: ( )*
Who will be responsible for the payment (including copayments) of the services?		
Name:		
Phone Number:	*Relationship to client:*	

	NO	**YES,** *please specify*
Do you have any significant current medical problem?		
Do you use tobacco?		
Do you use alcohol?		
Do you engage in any recreational drugs?		
Do you use caffeine daily?		
Have you ever had previous psychological care or counseling?		
Have you ever been hospitalized for a psychological problem?		
Have you ever been in a recovery program for an addiction?		
Have you ever attempted suicide?		
Have you ever been involved in domestic violence/rape/abuse (witness/victim/abuser)?		
Have psychiatric medications ever been prescribed for you?		
Do you exercise regularly?		
Have you ever gained or lost more than 15 pounds in a short time (e.g. 30 days)?		
Are you having any current sleep problems?		

Client's Signature _____ Date _____

Parent / Guardian Signature _____ Date _____