Stillwell
COUNSELING SERVICES
Individual and Family Counseling

Patient Information

Name:_____ **DOB:**_____ **Sex: Male Female**

Street:_____**Marital Status:**_____

City:_____**State:**_____**Zip:**_____**SS#:**_____

Home Phone:_____**May we call you at home?**_____**At work?**_____

Work Phone:_____**Employer:**_____

Cell Phone:_____**Email:**_____

Medical Information

Physician's Name:_____**Date of last physical exam:**_____

Are you on any regularly prescribed medications?_____ **If so, please list them:**

By whom were you referred to this practice?_____

Spouse/Parent Information

Name:_____**DOB:**_____**Sex: ___Male___Female**

Street:_____**Marital Status:**_____

City:_____**State:**_____**Zip:**_____**SS#:**_____

Home Phone:_____**May we call you at home?**_____**At work?**_____

Work Phone:_____**Employer:**_____

Cell Phone:_____**Email:**_____

***Others living in your household*:** _____**DOB:**_____

_____**DOB:**_____

To whom shall we mail your monthly statement? *Please note that we will bill charges to your insurance carrier if you desire. However, a statement will be mailed to you each month as well. You are responsible for payment of all charges until your insurance company pays.*

Responsible Party:_____**Relationship to Client:**_____

Street:_____**City:**_____**State:**_____**Zip:**_____

Home Phone:_____**Work Phone:**_____**SS#:**_____

Employer:_____

***In case of an emergency, please contact*:**

Name:_____**Phone:**_____

Relationship to Client:_____