Empower Counseling Services, LLC

Date:_____ **Catherine W. Harman, MS, LPC/S**

Personal Information

Full Legal Name of Client: _____
Age: _____ DOB: _____ Marital Status: _____
Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Is it ok to contact you and leave messages at the numbers and E-Mail above? _____
Employer & Position: _____
Who referred you for Counseling? _____
Emergency Contact Person: _____
Emergency Contact Phone No: _____

Doctor and Medicines

Family Physician Name: _____
Physician Phone No: _____
Physician Group Name: _____
Psychiatrist Name (if applicable): _____
Psychiatrist Phone No.: _____
Psychiatrist Group Name: _____
List all medicines you are currently taking: _____
_____
_____
_____
_____

Mental Health History

Previous Counseling? Yes _____ No _____
Name of Therapist: _____
Approximate Dates of Treatment: _____
Hospitalizations: Yes _____ No _____
Hospital: _____
Date(s): _____
Circumstances: _____
_____

Additional Information

Do you currently use any of the following substances?
Alcohol Yes ___ No ___ If yes, how much? _____
Cigarettes Yes ___ No ___ If yes, how much? _____
Caffeine Yes ___ No ___ If yes, how much?
Other chemical substances (e.g. marijuana, cocaine, etc.)
Yes ___ No ___ If yes, how much? _____
How much sleep do you routinely get each night? _____
Do you have any sexual concerns? Yes ____ No _____
If yes, please describe: _____
_____

Insurance Information

Insurance Company: _____
Insured's DOB: _____
Insured's Name:
Insured's Social Security No.: _____
A copy of your insurance card will required on the date of your initial assessment.

If Patient is a Minor

Mother's Name: _____
Mother's Phone No.: _____
Father's Name: _____
Father's Phone No.: _____

By my signature below I grant permission for my minor child to seen in therapy by Catherine W. Harman, MS, LPC/S

_____ _____
Signature Date

Briefly describe your main concerns and what you hope to gain from counseling:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____