Chrysalis Counseling
Claudine Miller, LPC • 7526 Big Bend Blvd., 2nd Floor, Webster Groves, MO 63119 • 314-780-8328

Client Information

Today's date: _____

A. Identification

Your name: _____

Date of birth: _____ Age: _____Nicknames or aliases:_____

Gender: _____ Marital Status: _____ Employment: No FT PT Retired Student

Home street address: _____

City: _____

State: _____ Zip: _____

Home/evening phone: _____ cell: _____

email:_____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

_____

B. Insurance Information **None** **Insurance company:**_____

Insured name:_____ Insured DOB:_____

Relationship to Insured: Self Spouse Child Other:_____

Insured employer's Name: _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Do you have any significant past medical issues (cancer survivor etc.) _____

_____

_____

Do you have any current medical issues (diabetes, heart disease, thyroid)?_____

_____

_____

(Please complete the other side)

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Current Medications:

Name of medication	dose	Reason for taking Medication

D. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ _____ Phone: _____

Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

D. Referral: Who gave you my name to call?

Name: _____How did this person explain how I might be of help to you? _____