Counseling Ministry
Diana C. Brawley, LCSW, ACSW, ThM, MDiv
(434) 987 – 6097

PATIENT INFORMATION

Date: _____ / _____ / _____

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Home Address: _____

City, State, Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Employer/School: _____

Reason for requesting counseling: _____

_____

Have you been treated for mental health services before? _____

_____

If yes, what dates and with whom? Please list treating clinician's name: _____

_____

Are you currently taking any medications? If yes, please list: _____

_____

Were you referred by anyone? _____

_____

RESPONSIBLE PARTY INFORMATION

If the patient is a minor or unemployed, please provide information about the person responsible for making payments:

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Home Address: _____

City, State, Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Health Plan/Member ID#: _____

Relationship to Patient: _____

Employer: _____

EMPLOYMENT INFORMATION

Patient / Responsible Party Employer: _____

Business Address: _____

SPOUSE / SIGNIFICANT OTHER INFORMATION

If the patient is a minor, please provide information about the other parent or guardian:

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Home Address: _____

City, State, Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Employer: _____

EMERGENCY CONTACT INFORMATION

Primary Care Physician: _____ Telephone: _____

Emergency Contact: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

I understand that the above is true and correct to the best of my knowledge. I received a packet of information confidentiality.

_____ _____

Signature (Patient) Date

_____ _____

Signature (Legal Guardian) *if applicable* Date

_____ _____

Signature (Legal Guardian) *if applicable* Date