Barbara Van Felix

Licensed Clinical Social Worker, Professional Corporation

LCS 11493

1212 High Street Auburn, CA 95603 Tel: (530) 887-8455

INFORMATION SHEET

Date: ____________

Name of Client: ______________________________________

Address: ______________________________________

____

May I contact you at home (address & phone): Yes/No? (Circle response) At work: Yes/No? (Circle response)

Phone # home: _________________ Date of Birth: __________ Age: ___

cell: _________________

work: _________________ Soc. Sec. #: _________________ OR

email: _________________ Driver's License#: ____________

Members of Household:

Name	Age	Relationship
_________________	___	_____________
_________________	___	_____________
_________________	___	_____________
_________________	___	_____________

Name of Medical Doctor: _________________ Phone #: __________

Medical Insurance: ______________________

Health Problems/Concerns: ____________________________________

Medications & Dosages: ______________________________________

Previous Counseling/Psychiatric Hospitalizations: _________________

____

To contact in case of emergency: _______________________________

Reasons you are seeking therapy at this time: _____________________

____

____

How referred: ____

Method of Payment: ___check ___cash ___insurance/EAP