Barbara Van Felix

Licensed Clinical Social Worker

LCSW 11493

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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