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Clinical and Consulting Psychology
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Please complete as much as possible, including your signature for consent to treat on the reverse side.

A. *Client data.* Today's date: _____
Client's name: _____ Date of birth: _____
Marital status: _____ Age: _____ Sex: _____ Race: _____
Address: _____
Street City State Zip
Home phone: _____ Work phone: _____
Cell phone: _____ Emerg. contact name & phone: _____
Place a check-mark in the box of the phone number above where messages may be left.
Email: _____
Client's Social Security #: _____ Highest education attained: _____
Who referred you to us? _____

B. If client is a minor, please complete the following section.

School: _____ Current grade: _____
School adjustment (academic and social): _____

C. Please provide the names of family members and other requested information. If the client is an adult, list the names of spouse and children, if any. If the client is a child, list the names of the child's parents and siblings, if any.

	Name	Date of birth	Level of education
Father or husband	_____	_____	_____
Mother or wife	_____	_____	_____
Siblings or children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please turn page over and complete.

D. Medical History

Family physician: _____ Date of last exam: _____

Condition of health (circle one): excellent good fair poor

Describe any medical problems: _____

Allergies: _____ Hospitalizations: _____

List past medications taken (dosage): _____

List current medications taken (dosage): _____

E. Payment arrangements.

Person responsible for payment of services: _____

Employer: _____ Occupation: _____

Spouse's employer: _____ Occupation: _____

F. Please give a brief description of the concerns you, your child, or your family is experiencing along with an estimate of how long you have had these concerns.

Please list other counseling or treatment you and/or your family has received in the past and approximate dates.

What are the main objectives you want to accomplish through coming here?

What are your main supports? (circle) family friends church work associations spouse other (name) _____

G. Please check each statement below and sign and date at the bottom of this form.

- I voluntarily consent for myself (or my child, if a minor) to be evaluated and/or treated by Dr. Wojniak.
- All information shared with Dr. Wojniak will be kept confidential except when 1) serious harm to the client or another is being suspected or threatened; 2) a court case requires disclosure of otherwise privileged information; 3) notification of services being provided is made to your physician or another professional with your consent; 4) minimal billing information is provided to your insurance company.
- I understand that if at any time I become a risk to myself or someone else, Dr. Wojniak will contact the persons as needed, including family members, to assure that I receive the necessary treatment.
- I agree to be responsible for fees charged for services.
- I understand that it is my responsibility to verify insurance coverage and any authorization required.
- I agree that if I am unable to keep any appointments, I will give AT LEAST 24-HOUR CANCELLATION NOTICE to allow other patients the opportunity to schedule and to avoid a late charge (\$50.00).
- I have been given an opportunity to receive a copy of Daybreak Counseling's policies and practices to protect my health information.

Signature

Date