Balanced Life Counseling, LLC

BLC INITIAL CONTACT FORM

CLIENT INFORMATION **DATE**_____

Patient Name _____ Date of Birth_____
Last First MI

Address _____ Male _____ Female _____

_____
City State Zip Code

Cell Phone (_____)_____ Permission Call & Text for apt. reminder □Yes □No

In case of emergency Name _____ Phone # (_____)_____

RESPONSIBLE PARTY

Insured Name _____ Date of Birth _____
Last First MI

Address _____ Phone: (_____)_____

_____ (_____)_____
City State Zip Code

Cell Phone (_____)_____ permission to call & text for apt. reminder ___ Yes ___ No

Relationship to Client ____ SELF ____ PARENT _____ SPOUSE _____ CHILD _____ OTHER

Method of payment: circle one 1) Private pay 2)Insurance billing

Primary Care Physician _____ City, State_____

Medical conditions and medications _____

_____

Prior Counseling/Therapy _____ yes _____ no Date _____

Reason for Seeking Evaluation Today: _____

_____

_____

How long has this been a problem: _____

_____

Self-scale of your problem right now. 10 being worst and 1 being best _____

Client (parent/guardian) Signature _____