

LifeSpring Center

Mission Valley • Carlsbad • Rancho Bernardo • Webster
Phone (619) 298-8722 • Fax (619) 298-5235

INITIAL INFORMATION

Welcome to our office. Please read and complete these pages. Your therapist will come to the waiting room to meet you.

Name _____ Social Security # _____ Date of Birth _____

Spouse's Name _____ Social Security # _____ Date of Birth _____

Address _____ City _____ State/Zip _____

Employer _____ Position _____ Work Phone _____

Home Phone _____ Best Time to Call _____ Email Address _____

Marital Status _____ Date of Present Marriage _____

Church Affiliation (if applicable) _____

Children's Names & Ages _____

Who lives at your home _____

What is the major relationship issue or situation for which you wish counseling _____

What counseling have you had previously _____

What medications, if any, are you now taking _____

Person to notify in case of emergency _____

Address _____ City _____ State/Zip _____

Phone # _____ Relationship to you _____

Who Referred You _____ May we thank them for referring you? Yes _____ / No _____

Your therapist may _____ / may not _____ send you mail regarding upcoming conferences and seminars.

Your therapist may _____ / may not _____ identify him/herself when he/she calls your work.

Your therapist may _____ / may not _____ identify him/herself when he/she calls your home.

Date _____ Client Signature _____

**** PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE SIDE ****

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INSURANCE INFORMATION (if applicable)

Primary Insurance Company _____ Policy # _____

Group # _____ Policy Holder's Name _____

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____

Policy Holder's Employer _____

Patient's Social Security # _____ Patient's Date of Birth _____

Patient's Employer _____

Insurance Company Phone # _____

Secondary Insurance Company _____ Policy # _____

Group # _____ Policy Holder's Name _____

Policy Holder's Social Security # _____ Policy Holder's Date of Birth _____

Policy Holder's Employer _____