BROWARD COUNSELING SERVICES LLC

PATIENT NAME:_____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL

DOB: ____/_____/_____ AGE:_____ SOCIAL SECURITY# _____-_____-_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMAIL:_____ SEX: ____FEMALE _____ MALE

MARITAL STATUS: **PLEASE CIRCLE ONE:** SINGLE / MARRIED / DIVORCED / WIDOW / SEPARATED

HOME (_____) _____ CELLULAR (_____) _____

PREFERRED PHONE NUMBER TO REACH YOU AT: (_____) _____-_____

EMPLOYER NAME/COMPANY: _____

FULL TIME:_____ PART/TIME:_____

SCHOOL NAME:_____

PLEASE PROVIDE A CONTACT NAME & NUMBER TO BE USED IN CASE OF AN EXTREME EMERGENCY:

EMERGENCY CONTACT:_____ _____
NAME RELATIONSHIP TO PATIENT
TELEPHONE TO CALL : (_____) _____- _____

THERAPIST'S NAME:_____ REFERRED BY:_____

PATIENTS SIGNATURE: _____

DATE: _____/_____/_____

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261 N. University Dr STE 300 Plantation, FL 33324 TEL 404-615-0262
www.browardcounselingservices.com

FAMILY HISTORY:

FATHER: LIVING_____DECEASED_____ IF DECEASED, YOUR AGE AT TIME OF HIS DEATH:_____

CAUSE OF FATHER'S DEATH?_____

IF FATHER IS ALIVE, FATHER'S CURRENT AGE?_____ HEALTH:_____

OCCUPATION:_____

MOTHER: LIVING _____DECEASED_____ IF DECEASED, YOUR AGE AT TIME OF HER DEATH:_____

CAUSE OF MOTHER'S DEATH?_____

IF MOTHER IS ALIVE, MOTHER'S CURRENT AGE?_____HEALTH:_____

OCCUPATION:_____

SIBLINGS: NUMBER OF BROTHERS _____ THEIR AGES:_____

NUMBER OF SISTERS _____ THEIR AGES:_____

CHILDREN: NUMBER OF SONS _____ THEIR AGES:_____

NUMBER OF DAUGHTERS_____THEIR AGES:_____

RELIGION: A) IN CHILDHOOD:_____ B) AS AN ADULT:_____

CLINICAL DATA:

THE NATURE OF YOUR CONCERNS AND THEIR DURATION, WHICH HAVE LED YOU TO SEEK COUNSELING AT THIS TIME:
CONCERNS:_____
_____
_____

GIVE A BRIEF DESCRIPTION OF THE HISTORY AND DEVELOPMENT OF YOUR CONCERNS (FROM ONSET TO PRESENT)

_____
_____
_____

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ON THE SCALE BELOW PLEASE ESTIMATE THE SEVERITY OF YOUR PROBLEM: (PLEASE CIRCLE)

MILD ***MODERATE*** ***EXTREME***

PLEASE LIST ANY THERAPIST OR PSYCHIATRIST WHOM YOU HAVE CONSULTED:

LIST NAMES AND
ADDRESSES:_____
_____
_____
_____
_____

PRIMARY PHYSICIAN NAME:_____ TELEPHONE NUMBER: (_____)_____

CURRENT PSYCHIATRIST NAME_____ TELEPHONE PHONE (_____)_____

ARE YOU TAKING ANY MEDICATION? IF YES, WHAT, HOW MUCH, AND WITH WHAT RESULTS?
_____
_____
_____

WE BELIEVE WE CAN OFFER THE UTMOST QUALITY OF CARE BY WORKING AS A TEAM WITH YOUR OTHER HEALTHCARE PROVIDERS. PLEASE INITIAL BELOW: I AM WILLING TO ALLOW **"BROWARD COUNSELING SERVICES LLC**" TO PROVIDE INFORMATION REGARDING MY CARE TO MY

NAME	INITIAL	
PRIMARY CARE PHYSICIAN: _____	_____	____YES ____NO
PSYCHIATRIST_____ ___	_____	____YES ____NO

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PAYMENTS AND BALANCES DUE ON MY ACCOUNT. SERVICES ARE PRIVATE PAY. NO INSURANCES WILL BE BILLED FOR PAYMENT. PAYMENTS WILL BE MADE TO "**BROWARD COUNSELING SERVICES LLC."**

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

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