Jo Ann Kaminsky, MEd. LPC
641 W Martin Luther King Jr. Boulevard
Fayetteville, AR 72701
479-587-1387

Client Information

Name______________________________________

Address____________________________________

Home Phone_____________Work____________ Cell __________

Age____ Birthdate____/___/____ SS#____ ___ ____

Sex M F Marital Status S M D W

	Name	Age	Relationship
Others in Home	_____________	_______	___________________
	_____________	_______	___________________
	_____________	_______	___________________
	_____________	_______	___________________

Referred by ____

Primary Care Physician________________________________

Phone________________Allergies______________________

Client Information page 2

Insurance Information
(If this information is the same as first page just put same)

Insured's name______________________Birthdate____/___/______

Address___________________________ZIP______________

Home
Phone______________Work_____________SS#____/___/____

Employer_________________________________

Relationship to client_______________________

Primary Insurance Carrier____________________

Phone(___)_____________Insured's ID #__________________

Insurance Group #_________________________________

Secondary Insurance Carrier________________________

Phone(___)____________ Insured's ID #___________________

Insurance Group #__________________________

May I contact you by phone yes____ no ____ What number is

preferred? Home Work Cell

When were you last seen by your Primary Care Physician?

__________ Why? __________________

Client Information page 3

Do you take medication? (Please include over-the-counter medication)

Medication	Dosage	How often	Who Prescribed

Do you have or is there a family history of; (Please us F for family history and M for My history)

___Diabetes ____Hypertension ____Arthritis ____Asthma

____Low blood sugar ____Hypothyroid _____Hepatitis _____HIV

____Anemia ____Hyperthyroid _____Head Injury ___Back injury

____Cancer ____Mental Illness _____Epilepsy _____Syphilis

____Drug/Alcohol Abuse _____Mononucleosis ____Viral Pneumonia

If you checked any condition above, please explain

____

____

Please list any other medical history (current or past) for yourself and the name of the treating physician________________________

____

Client Information page 4

Do you use any form of tobacco? ___No ___yes What?_________

How Much?_________

Please list current use of alcohol and/or other substances for your self

Habit	How Much?	How Often?	Last Use

Past use of alcohol and/or other substances for yourself

Habit	How Much?	How Often?	Last Use

Please list current and past mental health treatment and treating Clinicians

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I certify that the above information is correct and hereby authorize Jo Ann Kaminsky to provide mental health services to me. I agree to be responsible for payments of these services.

Date____________ Client___________________________

I hereby request and authorize assignment of insurance benefits to Jo Ann Kaminsky. I understand that this assignment may be terminated with written notification to Jo Ann Kaminsky

Date____________Client___________________________