December 2018

Jo Ann Kaminsky, MEd. LPC, ATR-BC, RPT-S
2227 N College
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_____

Insurance Information
(If this information is the same as above just put same)
Insured's name_____Birthdate____/___/_____
Address_____ZIP_____
Home
Phone_____Work_____
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 2

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_____
_____

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

_____

_____

Client Information page 3

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_____

Dater_____Parent if a minor_____

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_____

Date_____Parent if a minor_____