Deana M. Enebo-Short, MA LMHC
Enebo-Short Counseling Services, Inc
5610 Kitsap Way Suite 350 ~ Bremerton, WA 98312 ~ 360-479-6327
4020 S 56th St, Suite 212 ~ Tacoma, WA 98409 (for mail please use Bremerton address)
www.NWFamilyCounselingServices.com

CLIENT INFORMATION:

Your assistance in completing this questionnaire will be helpful in planning services for you. If there is any information you would prefer not to share with your therapist please make your therapist aware of this.

General Information:

Full Name_____ Date:_____

Mailing Address:_____
PO Box or Street Apt number

_____
City State zip

Telephone: Home (___)_____ OK to leave a message for you there? Yes No

Work (____)_____ OK to call you at work &/or leave a message? Yes No

Cell (____)_____ OK to leave a message? Yes No

Which is best to reach you during the day? _____

Age: _____ Date of Birth: _____ Social Security #:_____

Education: Last grade completed _____ HS Grad GED 13+ AA BA MA PhD

Single Married …How long? ____ Separated ____ Divorced ____

Occupation:_____ Years in this occupation? _____

Place of Employment:_____ Years employed here?_____

Name of Parent/Spouse/Guardians: _____

Is your spouse/parents supportive of your seeking counseling? Yes No

Children/Siblings in household:_____ Name(s)/Sex/Age(s): _____

_____

Others in household: _____

Sibling position in family of origin: ___of_____ (i.e. 2nd of 4)

How did you hear of me?_____May I thank them? yes no

Person responsible for bill: __ self or: Name: _____ Relationship to you: _____
(If you are using insurance coverage please complete insurance information on the last page completely.)

Date of Birth: _____ Social Security #: _____

Address (if different): _____

Home phone: (___)_____ Day time phone: (___)_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Does this individual live with you? Yes No

Circle any of the items below which resulted in your coming for counseling:

Depression or Anxiety	*Sexual orientation questions*	*Relationship enhancement*
Alcohol or Drug use	*Difficulty with loss or death*	*Abuse (physical/sexual)*
Relationship Problems	*Thoughts of harming yourself or others*	*School/life adjustment issues*
Communication difficulties	*School learning difficulties*	*Individual counseling*
Child adjustment/parent conflict	*Family counseling*	*Other:* _____

As you see it, what is presently bothering you the most?:_____

_____

How concerned are you about this? *Not concerned Low Moderate Seriously Very Concerned*

How often does it occur? *Rarely Sometimes Frequently Nearly Always*

Has anything like this happened before?_____ When? _____

How would you like to change things? _____

What do you do to help feel better? _____

Ideally, what would you like to get from therapy? _____

_____

Are you having any suicidal or homicidal thoughts? Yes No In the Past? Yes No

Have you or a family member had prior counseling? Yes No

Have you ever taken Psychiatric medication, if so which ones? _____

Have you ever used drugs for other than medical purposes? Yes No

- Therapist's name(s) and/or Agency: _____
- Approximate date(s) and length of services: _____
- Issues addressed: _____

  This experience was: *very helpful somewhat helpful not helpful made things worse.*

Medical Information:

Primary Physician:_____Last seen? _____ Telephone (___)_____

Address: _____

Current or chronic health problems for which you are receiving treatment: *If yes, please describe.*

_____

_____

List any medications you are currently taking: (this information is mandatory if you are using insurance)

_____

_____

Use another page if more room is needed.

Family Information:

Family of Origin: Name Age Describe the relationship with each

Father: _____ _____ Excellent Good Fair Poor Non-existent

Mother: _____ _____ Excellent Good Fair Poor Non-existent

Are they still married to each other? _____

Primary Insurance

Subscriber's name: _____ Relationship: _____

SSN:_____ Date of Birth: _____ Employer: _____

Employer's Address: _____

Employer's Phone: _____

Insurance Co: _____ Group #: _____Subscriber #: _____

Annual Deductable: _____ Has Deductible been met? __ Co-Pay or Co-Ins:_____

Is pre-authorization required? _____ Has it been obtained? _____

Secondary Insurance: (If there is any other insurance that may apply you must complete this section)

Subscriber's name: _____ Relationship: _____

SSN:_____ Date of Birth: _____ Employer: _____

Employer's Address: _____

Employer's Phone: _____

Insurance Co: _____ Group #: _____Subscriber #: _____

Annual Deductable: $____ Has Deductible been met? _____ Is pre-authorization required? _____
Has it been obtained? _____

Do you have other insurance? _____

I agree to inform Deana M Enebo-Short, LMHC if any information on this form changes. I understand it is my responsibility to confirm insurance benefits and that I am responsible for all fees, whether or not I have insurance coverage. Deana M Enebo-Short, LMHC has my permission to bill my insurance company. I authorize the release of any medical information necessary to process these claims. I understand that I am responsible for all charges for services provided, including late, cancellations (less than 24 hours notice) and no-show fees, whether or not paid by my insurance company. I understand that I will be held additionally responsible for all collection and attorney fees necessary to collect fees owed. I understand that all co-payments need to be made at the time of service and that additional billing charges and statement fees may be added to co-payments not made at the time of the session. I understand that I am personally responsible to confirm my insurance benefits and whether or not my therapist is covered by my insurance.

_____ _____

Signature Date