

SABITA NANDY M. Sc., Ed. S., LMFT
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CLIENT/FAMILY INFORMATION SHEET



DATE	SSN	
INSURED NAME	D.O.B.	AGE
PATIENT NAME	D.O.B.	RELATIONSHIP TO INSURED
ADDRESS		CITY
STATE	ZIP	HOME/CELL PHONE
EMPLOYER/SCHOOL		WORK PHONE
PROFESSION		E-MAIL

INSURANCE INFORMATION

INSURANCE COMPANY

POLICY/GROUP/AUTHORIZATION NO.

INSURANCE PHONE

RELATIONSHIP STATUS:	NEVER MARRIED	MARRIED	DIVORCED	SEPARATED	WIDOW(ER)	COHABITING
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICIAN

PHONE

MEDICAL CONCERNS

CURRENT MEDICATIONS

PREVIOUS OR PRESENT COUNSELING OR THERAPY: YES NO

WHEN _____ WHERE _____

NAME OF THERAPIST OR COUNSELOR

PHONE

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC PROBLEM?

NO YES WHEN _____ WHERE _____

REASON

SOURCE OF REFERRAL

REFERRAL SOURCES WILL BE CONTACTED TO INFORM THEM THAT YOU HAVE BEEN SEEN FOR AN INITIAL INTERVIEW

LIST ALL INDIVIDUALS LIVING AT HOME:

NAME	RELATIONSHIP	AGE	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST OF ALL INDIVIDUALS THAT MIGHT BE INFLUENCING YOUR LIFE

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

CONCERNS CHECKLIST: ARE YOU NOW OR HAVE YOU EVER BEEN CONCERNED ABOUT

(PLEASE MARK ALL THAT APPLY TO YOU)

PHYSICAL VIOLENCE	<input type="checkbox"/>	SEXUAL ABUSE	<input type="checkbox"/>	RAPE	<input type="checkbox"/>	DRUG/ALCOHOL USE	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	SEXUALITY	<input type="checkbox"/>	RACIAL/ETHNIC ISSUE	<input type="checkbox"/>	FINANCES	<input type="checkbox"/>
LEGAL INVOLVEMENT	<input type="checkbox"/>	HOUSING	<input type="checkbox"/>	SUICIDE	<input type="checkbox"/>		
OTHER	_____						

BRIEFLY DESCRIBE THE PRIMARY CONCERN THAT BROUGHT YOU HERE

AGREEMENT OF PAYMENT

I understand that I will be responsible for payment of all services provided. I also give Sabita Nandy permission to bill my insurance company on my behalf.

THERE IS A 24 HOUR LEEWAY FOR CANCELING APPOINTMENTS. IF YOU KNOW THAT YOU WILL NOT BE ABLE TO KEEP AN APPOINTMENT PLEASE CALL AT LEAST 24 HOURS IN ADVANCES. SERVICES WILL BE DISCONTINUED AFTER THREE CONSECUTIVE MISSED OR CANCELED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE.

SIGNATURE

INITIALS FOR E-MAIL SUBMISSIONS

PRINT NAME

DATE _____