

STENZEL CLINICAL SERVICES, INC.

Please fill out the following information as completely as possible.

Date: _____

Full Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell: _____

Date of Birth: ____/____/____

Subscriber Relationship to Client: Self ____ Spouse ____ Parent ____

(please complete below if other than self)

Subscriber Name: _____ Subscriber's Date of Birth: ____/____/____

Marital Status: Single ____ Engaged ____ Married ____ Separated ____
Divorced ____ Widowed ____

If married, spouse's name: _____ Age _____

Spouse's occupation and place of employment _____

Number of years married _____

If you have children, please list their names and ages:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Place of Employment: _____

Job Title: _____ Number of years at current job: _____

Highest education completed: High school/GED ____ Some college ____ College ____
Graduate/other ____

Is there a racial or ethnic group you identify with (or your parents) that you'd like me to be aware of?

Do you consider your spiritual life a resource? Yes _____ No _____

What is your religious affiliation (optional) _____

Attendance: Regularly _____ Sometimes _____ Never _____

How were you referred to Stenzel Clinical Services, Inc.?

Insurance Co. _____ Physician _____ School _____ Church _____
Friend _____ Other _____

The following questions are designed to help me understand your background. Please complete them as they apply to you. Thank you.

Parent's names: (F) _____ Age _____ Deceased _____
(M) _____ Age _____ Deceased _____

Married _____ Separated _____ Divorced _____ Widowed _____

Number of brothers _____ sisters _____

Has anyone in your family of origin had counseling? Yes ___ No ___ If so, for what?

Is there any history of drug or alcohol abuse in either of your parent's families?

Yes _____ No _____ If yes, please describe. _____

Was there any physical, sexual, or emotional abuse done to you or your siblings?

Yes ___ No ___ If yes, please describe _____

Are you in any way fearful of your current partner? Yes ___ No _____

Does your partner have angry outburst or temper tantrums? Yes ___ No _____

Has your partner ever pushed, grabbed, slapped, or hit you? Yes ___ No _____

Please list any specific medical conditions that you have _____

Are you taking any prescription medications at this time? Yes ___ No _____

If yes, what are they? _____

How long have you been taking this? _____ Who prescribed it for you? _____

What is your daily or weekly alcohol intake? _____

Do you have a past or current history of other drug abuse? Yes, current ___ Yes, past ___

No ___ If yes, please list _____

Have you been in therapy in the past? Yes ___ No ___ If yes, when, for what, how long, and with whom? _____

Was the therapy helpful? _____

What is your reason for contacting Stenzel Clinical Services, Inc and seeking therapy?

What are your goals for therapy? _____

Is there anything else that you feel is important to this therapy process?

Please fill out the authorization of benefits page if you plan to use your insurance for payment. In addition, please fill out the checklist and return this form to your therapist. We look forward to working with you.

Signature and Authorization of Benefits

Patient or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits to myself or to the party who accepts assignment.

Signed _____ Date: _____

Insured or Authorized Person's Signature:

I authorize payment of medical benefits to the undersigned physician, therapist, or supplier for services described above:

Signed _____ Date _____