LifeLine Professional Counseling Services
2460 W. Ray Rd., Suite 1
Chandler, AZ 85224
Tel: 480.641.1165 Fax: 480.641.9026

Clt Name:______________________
Clt ID #:______________________
Today's Date:____________________

Personal Information

Patients/ Parents/Guardians: please fill in all requested information.

A. Identification of Patient:

Patients name: ______________________________ Date: __________ Age: __________

Patients SS #:_____/______/_______Patients Birthdate: _____/______/______Hm phone: (_______)____________

Address: ______________________________City:____________Zip: ____________

Wk phone:____________________Cell:______________________E-mail________________________

Patient Status: ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Single ☐ Married ☐ Other
Is Patients Condition Related to: ☐ Employment ☐ Auto-Accident ☐ Other Accident?
Please indicate any phone or e-mail restrictions:______________________________

B. Parent/Guardian Information *(if applicable)*:

Patients Mother/Guardian:________________________SS#:_____/_______/______Birthdate ___/_____/___

Address: ______________________________City:____________Zip: ____________

Hm phone:____________________Cell:______________________ E-mail:________________________

Employer: ________________________ Address: ________________________

Work Phone: ______________ please indicate any call or e-mail restrictions: ________________

Patients Father/Guardian:________________________SS#:______/_____/______Birthdate ___/_____/___

Address: ______________________________City:____________Zip: ____________

Hm phone:____________________Cell/pgr____________________ E-mail:________________________

Employer: ________________________ Address: ________________________

Work Phone: ______________ please indicate any call or e-mail restrictions: ________________

C. Medical Care: From whom or where does the Patient receive medical care? *Please fill in all info. Keep therapist updated on any medical or medicine changes.*

Clinic/Doctor's name: ______________________________ Phone: ________________

Address: ______________________________City:____________Zip:______________

List All Medications Currently Taken:______________________________________

List Any Psychological/Psychiatric Medications Past or Present: ______________________________

____

If treatment is entered for psychological problems, I may ask to consult with your medical doctor so that he/she can be fully informed and we can coordinate your treatment if necessary? ☐ Yes ☐ No

D. Insurance Information: In order to make a copy, please have your insurance card ready at first visit.
{Important: get as much info from your employer or benefits department before starting therapy in order to process your claims quickly & efficiently}

Insured Name: ______________________________________Birthdate:____/_____/______

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured SS#: ________/_________/________

Employer's Name ________________________Insurance Plan Name: ________________________

Insurance ID #:__________________Group #: __________________Policy #:__________________

Insurance Phone#: __________________Fax #: __________________Contact Person________________

Insurance Address: ________________________City______________St_______Zip__________

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.