Hood County Counseling Center

Belinda Tuck Counseling

DATE:_____________________

Name:_________________________________ D.O.B.________________________

Drivers License #:________________________ S.S. #:_________________________

Address:___________________________________ City, Zip______________________________

2nd Client (IF Applicable, parent – if client is minor)

Name:_________________________________ D.O.B._________________________

Drivers License #:________________________ S.S.#:__________________________

Address (If different than above)________________________________City, Zip__________________________

PHONE NUMBERS

Home:____________________________ 2nd Client: Home:_________________________

Work:____________________________ Work:__________________________

Cell:______________________________ Cell:___________________________

What Kind of Appt. Reminders Do You Prefer?

_____Text Message (to what number?)_______________________

_____Phone call (to which number and can we leave message?)________________________Yes______No_____

If Insurance will be used, fill in this section:

Insurance Company____________________________________ Ins. I.D. #__________________________

Ins. Group #______________________________________

Patient's relationship to insured:_____Self_____Spouse_____Child_____Other

Insured's Name:____

Insured's Address:______________________________________

Insured's City, State:____________________________________Zip:___________________

Insured's Employer:____

Medications:

_____________________________ ____________________________ ______________________

_____________________________ ____________________________ _______________________

Reason for Counseling:

Depression/Anxiety | Anger | Substance Abuse

Grief/Stress | Hypnosis | Other___________________

Personal Issues | Relationship Problems | Divorce/Life Change

Work Related Issues

Previous Counseling:______Yes_____No **Referral:_____Phonebook_____Physician/Friend_____Other**