CRT COUNSELING-Change Renewal Transion, PA
Client Information Sheet

CLIENT NAME

Last :__________________First____________MI___ DOB___________SEX: M___F___

ADDRESS:________________________________CITY___________________________ZIP____

INSURANCE:______________ Member ID ____________________ SS#:______________

PHONE (H)_____________________ MESSAGES O.K.?____
(W)____________________ MESSAGES O.K.?____
(C)____________________ MESSAGES O.K.?____

SUBSCRIBER'S NAME:__________________________SS#____________________________

HOUSEHOLD MEMBERS

NAME:____________________________AGE_____RELATIONSHIP____________________
NAME:____________________________AGE_____RELATIONSHIP____________________
NAME:____________________________AGE_____RELATIONSHIP____________________
NAME:____________________________AGE_____RELATIONSHIP____________________

EMPLOYER:______________________ YEARS EMPLOYED________ TITLE______________

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE?_________REASON:_______________

NAME OF PHYSICIAN:__________________________PHONE #:________________________

CURRENT MEDICATIONS:______________________PRESCRIBED FOR:_________________

HAVE YOU EVER SOUGHT TREATMENT FOR SUBSTANCE ABUSE OR PERSONAL ISSUES BEFORE?______IF SO, PLEASE EXPLAIN:____

DO YOU CURRENTLY HAVE ANY LEGAL ACTION PENDING?______IF SO, PLEASE EXPLAIN:

ARE YOU ON PROBATION/PAROLE?______IF SO, PLEASE EXPLAIN:____________________

WHAT CHANGES DO YOU EXPECT FROM COUNSELING?____________________________

IN CASE OF EMERGENCY PLEASE CONTACT:___________________PHONE #:____________

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SCHEDULED APPOINTMENTS UNLESS A 24 HOUR CANCELLATION NOTICE IS GIVEN