Andrea Schneider, MSW, LCSW Counseling and Psychotherapy
Application for Treatment

_____ _____ _____ _____

Client's Name **DOB** **Age** **SSN**

_____ _____ _____ _____

Client's Address **City** **Zip** **Home Phone/Email**

_____ _____ _____

Occupation **Employer(s)/School** **Work Phone/Cell**

(If Applicable): for Child Treatment

_____ _____ _____

_____ _____ _____

Parent(s)/Guardian(s) Names **Address** **City** **Zip** _____

Home/Cell/Work Phone #s

(If Applicable): for Couples Treatment:

_____ _____ _____ _____

Client's Name **DOB** **Age** **SSN**

Responsible Party (if other than client):

_____ _____

Name **Phone**

_____ _____ _____ _____

Address **City** **Zip** **Relationship**

In Case of Emergency, Notify:

_____ _____

Name **Phone**

_____ _____ _____ _____

Address **City** **Zip** **Relationship**

Marital Status: **___Single ___Married ___Separated ___Divorced ___ Widowed __Cohabitating __ Remarried __ Other _____**

Primary Care Physician(s): _____ Phone:_____

Are you currently under medication?: __YES __NO
If yes, for what? _____
What medications (and dosages)?:_____
Any allergies?: _____
Briefly state the issue(s) that bring(s) you here:
_____
_____

_____
_____
_____

Signature:_____ **Today's Date:**_____

As a courtesy, I will Xerox your Insurance Card for verification purposes, during our session time. Please continue Consent/Registration on the next page. Thank you._____
_____

Office Only: DX (1) _____ **(2)**_____
Procedure code: (60)_____ **(90)**_____**Init#**_____
Co-payment rec'd_____