www.LouisLaves-Webb.com
(512) 914-6635

Confidential Client Information

Name_____ SS#_____

Address_____

City/State/Zip_____

Home/Cell Phone_____ Work Phone_____ E-Mail_____

Occupation_____ Employer_____

_

Gender_____ DOB_____ Age_____ Marital Status_____

Ethnic Background _____ Name of Physician_____

Insurance Co_____ Policy/Group #_____

Names(s) of previous therapist(s) and dates seen_____

Describe any health concerns_____

1_____

2_____

3_____

List drugs/medications you presently use_____

Referred by_____Phone_____

Please briefly describe the concern(s) that bring you here_____

1_____

2_____

3_____

Please check any of the following items which concern you:

___Self-esteem, self-confidence
___Anxiety, nervousness, fears
___Depression
___Sexual Concerns
___Anger, hostile feelings
___Traumatic experiences
___Physical distress
___Eating or appetite problems
___Alcohol or drug problems
___Sleep problems
___Parent-Child problems
___Other: _____

___Family conflicts or pressures
___Friendship conflicts
___Relationship/Marital Concerns
___Shyness, being assertive
___Loneliness
___Procrastination or motivation
___Gay/Lesbian issues
___Suicidal feelings or behaviors
___Stress
___Self-control
___Health problems
___Work or career concerns

Please put a *second* check next to those that are of *particular* concern to you right now.

Please list the members of your immediate family (include parents, siblings, spouse/partner, children, and all others in you home):

Name	Relationship	Age	Occupation	Education

Responsibility for payment by a third party

I agree to accept responsibility for the payment of all professional fees incurred for services provided to the following client:_____. I have read and understand the office policies described on a separate form. In understand that this agreement does NOT constitute a waiver of confidentiality between the therapist and the client, except as specifically authorized by the client below.

Signature:_____ Date:_____

Name and Address: _____

_____

Telephone: Cell_____ work _____ home_____

TO BE COMPLETED BY CLIENT: I request and authorize Louis Laves-Webb, LCSW, LPC-S to release information concerning billing, payments, fees, insurance, appointment dates, and missed sessions to the individual named above.

Signature:_____

Date:_____