***BROWARD CENTER FOR COUNSELING***
***8030 PETERS ROAD, SUITE D-106***
***PLANTATION, FL 33324***

PATIENT NAME:____________________________ ___________________________ ____________
LAST NAME FIRST NAME MIDDLE INITIAL

DOB: ____/_____/______ AGE:_____ SOCIAL SECURITY# ___________-____________-__________

ADDRESS:_________________________________________________________________________________

CITY:__________________________ STATE:_______________ ZIP CODE:__________________

EMAIL:_________________________________________ SEX: ____FEMALE _____ MALE

MARITAL STATUS: **PLEASE CIRCLE ONE:** SINGLE / MARRIED / DIVORCED / WIDOW / SEPARATED

HOME (________) ____________________________ CELLULAR (_______) _______________________

PREFERRED PHONE NUMBER TO REACH YOU AT: (___________) _____________-________________

EMPLOYER NAME/COMPANY: ______________________________________________________________

FULL TIME:__________ PART/TIME:___________

SCHOOL NAME:_________________________________________________________________________

***PLEASE PROVIDE A CONTACT NAME & NUMBER TO BE USED IN CASE OF AN EXTREME EMERGENCY:***

EMERGENCY CONTACT:______________________________ ___________________________________
NAME RELATIONSHIP TO PATIENT
TELEPHONE TO CALL : (___________) ___________________- __________________________________

THERAPIST'S NAME:_____________________________ REFERRED BY:____________________________

PATIENTS SIGNATURE: _____________________________________________________________________

DATE: __________/__________/______________



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**TEL 954-475-9503 FAX 954-476-2369**
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## HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION: **(PLEASE COMPLETE INFORMATION FOR POLICY HOLDER)**

POLICY HOLDER (NAME)__________________________________ DOB:______/_________/_______

RELATIONSHIP TO PATIENT:____________________________________________________________

INSURANCE CARRIER NAME:___________________________________________________________

MEMBER ID # ___________________________________ GROUP # ____________________________

EMPLOYER NAME/COMPANY:__________________________________________________________

INSURANCE TELEPHONE NUMBER FOR CUSTOMER SERVICE OR MENTAL HEALTH PROVIDERS:

(_______________) ___________________________________________________________________

SECONDARY INSURANCE INFORMATION: **(PLEASE COMPLETE INFORMATION FOR POLICY HOLDER)**

POLICY HOLDER (NAME):________________________________ DOB: ______/________/_________

RELATIONSHIP TO PATIENT:____________________________________________________________

INSURANCE CARRIER NAME:___________________________________________________________

MEMBER ID # ___________________________________ GROUP#:_____________________________

INSURANCE TELEPHONE NUMBER FOR CUSTOMER SERVICE OR MENTAL HEALTH PROVIDERS:

(_________________)__________________________________________________________________

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT ON MY ACCOUNT AND THAT **"BROWARD CENTER FOR COUNSELING"** WILL VERIFY MY INSURANCE BENEFITS AS A COURTESY. I UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ANY OFFICE CHARGES NOT PAID BY MY INSURANCE COMANY.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____________________________ DATE: ___________________

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## FAMILY HISTORY:

**FATHER**: LIVING_____DECEASED_____ IF DECEASED, YOUR AGE AT TIME OF HIS DEATH:________

CAUSE OF FATHER'S DEATH?______________________________________________________________

IF FATHER IS ALIVE, FATHER'S CURRENT AGE?____________ HEALTH:___________________________

OCCUPATION:___________________________________________________________________________

**MOTHER**: LIVING _____DECEASED_____ IF DECEASED, YOUR AGE AT TIME OF HER DEATH:________

CAUSE OF MOTHER'S DEATH?_____________________________________________________________

IF MOTHER IS ALIVE, MOTHER'S CURRENT AGE?__________HEALTH:__________________________

OCCUPATION:_________________________________________________________________________

SIBLINGS: NUMBER OF BROTHERS _______ THEIR AGES:__________________________________

NUMBER OF SISTERS _______ THEIR AGES:__________________________________

CHILDREN: NUMBER OF SONS ________ THEIR AGES:_________________________________

NUMBER OF DAUGHTERS_________THEIR AGES:_________________________________

RELIGION: A) IN CHILDHOOD:__________________ B) AS AN ADULT:________________________

**CLINICAL DATA:**

THE NATURE OF YOUR CONCERNS AND THEIR DURATION, WHICH HAVE LED YOU TO SEEK COUNSELING AT THIS TIME:
CONCERNS:______________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

GIVE A BRIEF DESCRIPTION OF THE HISTORY AND DEVELOPMENT OF YOUR CONCERNS (FROM ONSET TO PRESENT)
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

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ON THE SCALE BELOW PLEASE ESTIMATE THE SEVERITY OF YOUR PROBLEM: (PLEASE CIRCLE)

***MILD*** ***MODERATE*** ***EXTREME***

PLEASE LIST ANY THERAPIST OR PSYCHIATRIST WHOM YOU HAVE CONSULTED:

LIST NAMES AND
ADDRESSES:______________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

PRIMARY PHYSICIAN NAME:____________________ TELEPHONE NUMBER: (_______)______________

CURRENT PSYCHIATRIST NAME______________________ TELEPHONE PHONE (_____)______________

ARE YOU TAKING ANY MEDICATION? IF YES, WHAT, HOW MUCH, AND WITH WHAT RESULTS?
____________________________________________________________________________________
____________________________________________________________________________________
___________________________________________________________________________________

WE BELIEVE WE CAN OFFER THE UTMOST QUALITY OF CARE BY WORKING AS A TEAM WITH YOUR OTHER HEALTHCARE PROVIDERS. PLEASE INITIAL BELOW: I AM WILLING TO ALLOW **"BROWARD CENTER FOR COUNSELING**" TO PROVIDE INFORMATION REGARDING MY CARE TO:

| NAME | INITIAL | | |
|---|---|---|---|
| PRIMARY CARE PHYSICIAN: ___________________________ | _____ | ____YES | ____NO |
| PSYCHIATRIST___________________________________ ___ | _____ | ____YES | ____NO |