

Initial Data Form

Please fill in the following information:

Patient Name: _____

Address _____ City: _____

State: _____ Zip: _____

DOB*: ____/____/____ Highest level of Education: _____

Occupation: _____

Place of Work or Company Name: _____

Day Phone: _____ Home Phone: _____

Spouse or Parent Names: _____

Address _____ City: _____

State: _____ Zip: _____

DOB: _____ Highest level of education: _____

Occupation: _____

Place of Work or Company Name: _____

Day Phone: _____ Home Phone: _____

Purpose seeking counseling: _____

Issues and goals you would like to address: _____

Who referred you to Covenant Counseling? _____

Other counselors you or your family member has seen (Include the year and any diagnosis):

Indicate physical issues, past and present: _____

List stresses: _____

List patient medications: _____

Religious affiliation if any: _____

Circle to indicate the level of your spiritual interest: 1 2 3 4 5

Spouses spiritual interest: 1 2 3 4 5

Low Interest

High Interest

Do you use **alcohol**? Yes No Do you use uncontrolled substances? Yes No

Has either of these ever been a problem in your life? _____

Does the spouse use alcohol? Yes No Does the spouse use uncontrolled substances? Yes No

Has either of these ever been a problem in your life? _____

See Back

If applicable:

Present status (Circle One): single, married, separated or divorced

Your Present Marriage is you're: 1st, 2nd, 3rd, _____

Your Spouse's Present Marriage is the: 1st, 2nd, 3rd, _____

Your Children:

Name	DOB*	BAP♦ Indicate to which marriage the children were born or adopted.	Indicate A for adopted, B for biological parent.
—			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Spouse's Children:

Name	DOB*	BAP Indicate to which marriage the children were born or adopted.	Indicate A for adopted, B for biological parent.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Insurance:

Billing Address: _____

Secondary Insurance: _____
 Billing Address: _____

I understand that if my insurance fails to pay Covenant Counseling for any reason I am responsible for full payment of my account.

Signed: _____ Date: _____

Signed: _____ Date: _____

* Date of Birth

♦ **Biological or Adopting Parent:** Identify biological spouse by indicating the spouse is of which marriage using 1st, 2nd, 3rd, etc., P = present, or BSP = Born of single parent.