Covenant Counseling
212 West Wackerly, Suite 200
Midland, MI 48640

Date: ____________________

Initial Data Form

Please fill in the following information:

Patient Name: ____
Address ____ City: ____________________________
State: ________________________ Zip: ________________
DOB*: ____/___/______ Social Security #: __________________________________
Day Phone: __________________________ Home Phone: ___________________________

Highest Educational Degree __________________ Occupation: ____________________________
Place of Work or Company Name: ____

Spouse or Parent Names: ____
Address ____ City: ____________________________
State: ________________________ Zip: ________________
DOB*: ____/___/______ Social Security #: __________________________________
Day Phone: __________________________ Home Phone: ___________________________

Highest Educational Degree __________________ Occupation: ____________________________
Place of Work or Company Name: ____

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
* 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.