Resurgence Counseling Services

Where Restoration Begins

New Client Questionnaire

Todays Date: _____

Client Name: _____

Date of Birth: _____ Social Security # _____ - _____ - _____

_____

Street Address City/Sate Zipcode

Contact Phone #: _____ Alternate No#: _____

Emergency Contact #_____

Email Address:_____

Medical Insurance Carrier _____

Insurance Number _____

Relationship Status □ Single □ Married □ Separated □ Divorced □ Widowed

Name of Significant Other: _____

Highest Level of Education: _____

Job Status □ Full-time □ Part-time □ Unemployed □ Student

Name of Employer/School _____

Occupation: _____

Do you have children □ Yes □ No If yes how many? _____

List all the people who live in your household

Name	Age	Relationship

Previous Mental Health History (within past 2 years)

Psychiatrist Name/Facility: _____

Dates of Treatment: _____

Reason for seeking treatment: _____

Therapist Name/Facility: _____

Dates of Treatment: _____

Reason for seeking treatment: _____