

**ANNA D. SKINNER, LPC**

Licensed Professional Counselor  
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## Confidential Client Information (Page 1 of 2)

Welcome to my practice. Please fill out the following questions as completely as possible.  
PLEASE PRINT OR WRITE LEGIBLY.

Client's Name	Last	First	Middle	Marital Status:
				___ Single
Client's Address	Street:			___ Married
	City:	State:	Zip Code:	___ Living as Married
Phone	Home:	Work:	Cel:	___ Divorced
	Age:	Birthdate:	Birthplace:	___ Widowed
Education	Highest Grade:	Degree:	Field:	
	Religious Background:		Current Religion:	
Spouse	Name:	Age:	Occupation:	Yrs Married:
Children	M F Name:	Age:	M F Name:	Age:
	M F Name:	Age:	M F Name:	Age:
Were you raised by: Both Parents?      Single Parent?      Relative?      Other?				
Father's Name:		Age:	Occupation:	
Mother's Name:		Age:	Occupation:	
Brothers and sisters in birth order:	M F Name:	Age:	M F Name:	Age:
	M F Name:	Age:	M F Name:	Age:
	M F Name:	Age:	M F Name:	Age:
In your family was there a history of:    ___ Alcoholism    ___ Substance Abuse    ___ Mental Illness ___ Prolonged Physical Illness? What kind?				
Current Medications (Type, Dose):				
Medical Problems (past and present):				
Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric disorders?    ___ Yes    ___ No    Details:				

## Confidential Client Information (Page 2 of 2)

Have you had previous psychiatric care and/or counseling? (When, Where, How long):

Have you ever thought about killing yourself or hurting yourself on purpose? \_\_\_ Yes \_\_\_ No (If yes, when and how)

Have you ever attempted suicide? \_\_\_ Yes \_\_\_ No (If yes, when and how?)

Client or Guardian employed by:

Employer's address:

City: State: Zip: Phone:

Name of Insurance Company:

Name of Insured:

Group No.

Member No.

Driver's License No.

Social Security No.

Insurance company billing address:

City: State: Zip: Phone:

I, \_\_\_\_\_, understand and agree to pay Anna D. Skinner, LPC the amount of \$\_\_\_\_\_ at the conclusion of each \_\_\_\_\_-minute consultation. I understand that I am responsible for payment for consultations not cancelled 24 hours in advance. Payment for services is rendered at the conclusion of the consultation unless other arrangements have been made. I hereby authorize this clinician to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments. Any monies received by the clinician from the above insurance companies over and above my indebtedness will be refunded to me when my bill is paid in full. Furthermore, I have been informed both verbally and in writing of the HIPAA Privacy Practices of this clinician, as well as my Client Rights.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_