Mindful Beginnings of Lake Norman
A Counseling and Play Therapy Practice
17105 Kenton Dr. Suite 207C
Cornelius, NC 28031

Last Name First Name Middle Initial Maiden Name

Client:_____
_

Address:_____
City:_____

State:_____ Zip:_____ Birthdate:_____ Age :_____ Sex:
_____

Primary Phone:_____ Secondary Phone:_____

Email(s):_____
_

Legal Guardian(s) if applicable:
_____

Legal Guardian(s) Primary Phone:_____ Secondary Phone:_____

Legal Guardian Address(es):_____
_

Currently Living with:
_____

Relational Status: ___Single ___Engaged ___Married ___Domestic Partners
_____Separated ___Divorced ___Widowed

If therapy is for a couple or family, please list name(s), age(s) and preferred treatment involvement of additional family members:

Name: _____ Relationship:_____ DOB_____
Participant: YES NO

Name: _____ Relationship:_____ DOB_____
Participant: YES NO

Name: _____ Relationship:_____ DOB_____
Participant: YES NO

Name: _____ Relationship:_____ DOB_____
Participant: YES NO

In case of emergency who should be contacted?
_____

Relationship to you? _____ Phone: _____-
_____

EMPLOYMENT INFORMATION

Employment Status: _____Full-time _____Part-Time _____Seasonal _____Unemployed
_____Disability

Employer(s):_____

Occupation(s):_____

EDUCATION INFORMATION

School: _____ Grade Level: _____

Ever Retained? ___Yes ___No IEP: ___Yes ___No 504 Plan: ___Yes ___No

If yes, describe:
_____

CREDIT CARD INFORMATION Credit card on file is used to bill for sessions and any late cancelation & no show fees.

Name on Card: _____ Type of Card: _____

Card Number: _____ Expiration Date: _____

Security Number (On back of card): _____ Zip Code: _____ Client Initials:
_____

ALTERNATE PROVIDERS

Currently involved in any other counseling, psychiatric, or case management services? YES NO
Have you previously had counseling, psychiatric, or case management services? YES NO Was this experience positive and beneficial? YES NO

Do you give us permission to contact alternative treatment provider(s) to provide coordination of treatment? YES NO

Please initial giving consent to consult with alternate provider(s) listed below:
_____

Provider's Name: _____ Phone: _____

Referral Source: BCBS AETNA PSYCHOLOGY TODAY WEB SEARCH

OTHER:_____

Additional Comments:

_____

_____