Adult Questionnaire

Walter Camos, MS, LPC
Licensed Professional Counselor
102 Independence Boulevard, Lafayette, Louisiana 70506
337.322.3779 www.camostherapy.com info@camostherapy.com

Please answer the following questions to the best of your ability; your answers will assist me in better understanding your particular case. Any questions left unanswered will remain as questions upon your intake interview; therefore, please do your best. If you feel that any question is too personal, then you may inform me more about it when you come in, or choose not to divulge the information at all. I can only help to the degree that I may understand your particular case. This questionnaire will be treated as personal, confidential, protected information.

Date _____ How did you find out about us _____

Client Name_____ Date of birth _____ Age _____

Address _____ How long living at this address _____

City _____ State _____Zip _____

Home Phone _____ Social Security No. _____

Work Phone _____ Drivers License No. _____

Cell Phone _____ Level of Education _____

Place of Employment _____ Occupation _____

Employment Address _____City _____ State ___ Zip _____

Marital status: Never Married _____ Married _____ Separated _____ Divorced _____ Widowed _____

You have been in the current marital status for how many years now? _____

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Spouse's Name _____ Date of birth _____ Age _____

Address _____

City _____ State _____Zip _____

Home Phone _____ Social Security No. _____

Work Phone _____ Drivers License No. _____

Cell Phone _____ Level of Education _____

Place of Employment _____ Occupation _____

Employment Address _____City _____ State ___ Zip _____

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Please enter names and ages of your children below: Total number of Children _____

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_____

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Name of your Insurance Provider _____

Group # _____ Contract/Member ID# _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Place of Employment _____ Insured S.S. # _____

Employment Address _____City _____ State ___ Zip _____

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Nearest Relative not living with you:

Person's Name _____ Phone No. _____

In case of Emergency contact person:

Person's Name _____ Phone No. _____

Are you currently in the care of a Physician ? _____

Physician's Name _____ Phone No. _____

Current Medications and reasons for seeing Physician _____

_____

_____

Have you ever seen a Counselor, Therapist, Psychologist or Psychiatrist before? _____

If so, please give names, reasons, explanation, approx. dates: _____

_____

_____

Please explain your reasons for coming in for therapy today: _____

_____

_____

All of the information that I have provided herein is accurate and to the best of my ability. I have already reviewed and understand your Declaration of Practice and consent to the policies outlined; and want to be accepted as a client for treatment herein, as signed below:

Client's Signature _____ Date _____