Growth Pointe Wellness
Dana Graves, MA, LMHC
600 Main St, Suite D
Edmonds, Washington 98020
www.growthpointewellness.com
425.359.9801

Print and fill this out and bring to your 1st appointment or scan and email to:

dana@growthpointewellness.com

Client Information Form

Name: _____ Date: _____ Age: _____ Birth Date: ____/____/____ Gender: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Race: _____

Zip: _____ Email: _____ May we send e-mails: Yes☐ No☐

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Best number to reach you: ☐ Cell ☐ Home ☐ Work May we leave a message? Yes☐ No☐

Occupation: _____ Employer: _____ Education: _____

*Emergency Contact: _____ *Relationship:_____

Phone: _____ Religion/Spiritual Affiliation (if any): _____

Services Seeking: ☐ Counseling ☐ Coaching ☐ Case/Care Management ☐ Telehealth Services

Services For: ☐ Self ☐ Family ☐ Child/Teen Referred by _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Briefly describe your reason for seeking services today:

FAMILY INFORMATION

NAME (immediate family)	Relationship		Age	Living with you? Y or N

BILLING INFORMATION

Responsible party for payment /SUBSCRIBER Insurance Information:

Name: _____ Relationship to Client: _____
First Middle Initial Last

Address:_____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

email: _____ Birth Date: _____

Occupation: _____ Employer: _____

If using insurance coverage for counseling services:

Insurance Carrier: _____ ID No.: _____

Group No.: _____ Plan/Branch: _____

MEDICAL INFORMATION

When were you last examined by a physician? _____

Name of your Primary Care physician: _____

Physician's Address: _____ Phone: _____
Street City Zip Code

List any health problems for which you currently receive treatment:

_____

List any medications you are currently taking:_____

_____

Are you currently being treated by a psychiatrist or therapist? Yes☐ No☐ If so, list name(s) and phone # / contact info:

_____

List any previous psychiatric or psychological help or counseling experiences: (include Dr.(s) or therapist(s) & dates)

_____

_____

_____

Please add any additional information you would like: