Tri-County Health Network

TELETHERAPY

CLIENT INFORMATION FORM

Please complete all information in the space provided. We will contact you upon submission of all forms in order to schedule an appointment.

Today's Date: Click or tap here to enter text.

Client Name:

First: Click or tap here to enter text.

MI:Click or tap here to enter text.

Last: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text. Age: Click or tap here to enter text.

Grade (If Applicable): Click or tap here to enter text.

SSN: Click or tap here to enter text. Medicaid ID: Click or tap here to enter text.

Home Phone: Click or tap here to enter text. Cell Phone: Click or tap here to enter text.

Work Phone: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

How may we contact you: ☐ Call Home # ☐ Call Cell # ☐ Call Work #

Ok to Leave a Detailed Message: ☐ Leave call back # only: ☐

Mailing Address:

Street: Click or tap here to enter text. City: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

Physical Address:

Street: Click or tap here to enter text. City: Click or tap here to enter text.

Zip Code: Click or tap here to enter text.

Primary Care Physician: Click or tap here to enter text. Phone:Click or tap here to enter text.

Address: Click or tap here to enter text. City: Click or tap here to enter text.

TRI-COUNTY HEALTH NETWORK

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

Gender: ☐ Male ☐ Female……..List of others

Ethnicity: ☐ Caucasian……List of others

Emergency Contact Information:

Name:Click or tap here to enter text.

Relationship to Client: Click or tap here to enter text.

Emergency Contact Phone No. Click or tap here to enter text.

Parent/Guardian Information (if client is under 12 years old):

Name: Click or tap here to enter text.

Phone No.: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Number of family members living in your home: Click or tap here to enter text.

Are you in crisis: ☐ Yes ☐ No If Yes, please explain: Click or tap here to enter text.

Please call 911 if you are experiencing a life-threatening emergency. For mental health concerns, you can also call the Colorado Crisis Line at 844-493-2555, or call the Crisis Line at the Center for Mental Health at 970-252-6220.

Please describe why you are seeking services today:Click or tap here to enter text.

Have you had previous psychotherapy or counseling: ☐ Yes ☐ No

If so, when: Click or tap here to enter text. Was it helpful: Click or tap here to enter text.

Current medications: Click or tap here to enter text.

TRI-COUNTY HEALTH NETWORK

How did you hear about our teletherapy services:

☐ Newspaper Ad ☐ Article in Newspaper ☐ Radio ☐ Email

Or

Referred by: Click or tap here to enter text.

Best times of days to schedule appointments:

Day(s) of Week (Monday-Friday): Click or tap here to enter text.

Times of Day (between 10am and 5pm): Click or tap here to enter text.

Therapist preference: ☐ Male ☐ Female ☐ No Preference

Spanish speaking therapist: Click or tap here to enter text.

Please provide a copy of the front and back of your insurance card

Electronic Signature: Click or tap here to enter text.

Date: Click or tap here to enter text.

Signature of Parent or Guardian (if less than 12 years old): Click or tap here to enter text.

Printed Name of Parent or Guardian: Click or tap here to enter text.

In addition to this form, you must also read and sign the following forms:

☐ Disclosure Statement

☐ Notice of Privacy Practices

☐ Release of Information for Licensed Professional Counseling

☐ Minor Consent Form (if client is less than 12 years old)