CORNERSTONE COUNSELING CENTER, PC
6011 JONESTOWN ROAD
HARRISBURG, PA 17112

CLIENT INFORMATION SHEET
(Please Print)

Date: ____________________

Client Name: First: ________________________ MI ____ Last ___________________________

Date of Birth: ___/_____/______ Sex: M F SS#: ______ - ______ - _______

Address: ____

City: ____________________________________ State: _____ Zip: _______________

Phone: Home: ______________ Work _____________ Cell ______________

Circle if okay to leave message: Home Work Cell

E-Mail Address: ____

Employment Status: ___ Full-time ___ Part-time Occupation: ________________________

Name of Employer: ____

Student: ______ Full-time /Part-time: _______ Grade: _________

Name of School: ____

History of Difficulties with conduct, homework, peers, or authority: _________________________
____

Parents (if under the age of 18):

Mother Name: ________________________________ Birthdate: ____/____/_____

Address: ____

Phone number: _____-______-______

Father Name: _________________________________ Birthdate: ____/____/____

Address: ____

Phone Number: ______-_____- _______

Emergency Contact: ___________________________________ Relationship: ___________________

Phone Numbers: (Home) ___________________ (Cell) __________________________________

Name of your PCP: _____________________________________ Phone No.: ______________________

Current Medications:

____

____

____

____

Mental Health Treatment History (please check all that apply)

None: _________ Outpatient: _________ IOP/Day Treatment: _________

In Patient: _________ Self Help: ____________

Substance Use/ Abuse History: (please check all that apply)

None: _________ Alcohol: _______ Marijuana: _________

Cocaine: ________ Opiates: _______ Cocaine: __________

Tranquilizers: __________ Hallucinogens: ________

INSURANCE INFORMATION **Please supply your insurance card to be copied**

Insured ID # _____________________________ Policy/Group # ________________________

Insurance Company: ____

Insured Name: ____ Date of Birth: ____________

Insured Social Security Number: ____________________________

Client relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer: ______________________________________

SECONDARY INSURANCE If you have secondary insurance, please complete the following:

Insured ID # _____________________________ Policy/Group # ________________________

Insurance Company: ____

Insured Name: ____ Date of Birth: ____________

Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ other

Employer: ____