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: _____