Holly T Mitchell – TX LPC - Counseling Practice

Patient Information – ADULT

Patient's Name: Date of Birth: Age:

Referred By: Social Security Number:

Address: City/State:

Zip: Email Address:

Cell: Primary Care Physician:

Employer: Position: Length of Employment:

Marital/Relationship Status: Significant Other's Name.

Emergency Contact: (Name) (#)

Others in the home:

NAME	AGE	RELATIONSHIP TO PATIENT

Insurance Information

Insurance Provider:

Member ID: Group ID:

Name of primary carrier: DOB of primary carrier:

If you would like the clinician to verify your insurance coverage-
email a picture copy of your insurance card and photo ID to:
Hollytxlpc@gmail.com

List All Current Medications

MEDICATION	DOSAGE	DATE STARTED	PRESCRIBING DOCTOR

Has patient previously been in counseling: [ ] Yes [ ] No
Name of previous therapist: _____
_____
Date/Length of treatment: _____

List any psychiatric or inpatient treatment and dates: _____
_____

Describe presenting problem: _____
_____
_____
_____
_____
_____
_____

Date of onset: _____

Are you currently having thoughts of hurting yourself or others: [ ] Yes [ ] No

If yes, please describe: _____
_____

SIGN & DATE

_____ _____ _____
Signature of Person Completing Form Relationship to Patient Date