Kipp D. Trembley MA, CHt, LMHCA

Aspentree Counseling & Hypnotherapy
9481 Silverdale Way #209, PO Box 1734, Silverdale, WA 98383
360-920-7047

CONFIDENTIAL CLIENT INFORMATION

TODAY'S DATE_____

NAME_____ AGE_____ BIRTHDATE _____

ADDRESS_____ APT # _____

CITY _____ ZIP _____ EMAIL_____

WORK PHONE _____ CELL_____

HOME PHONE_____ SOC.SEC.#_____

EMPLOYER_____

EMPLOYER ADDRESS CITY ZIP _____

( ) SINGLE ( ) MARRIED: HOW LONG?_____ ( ) COUPLED, NOT MARRIED:____

( ) SEPARATED ( ) DIVORCED: HOW LONG?_____

( ) WIDOWED ( ) PREVIOUS MARRIAGES: HOW MANY?_____

PARENT/SPOUSE OR

PARTNER_____ AGE_____ BIRTHDATE _____

EMAIL _____

ADDRESS_____ HOME PHONE _____

WORK PHONE_____ CELL _____

EMPLOYER_____

SOC.SEC. #_____

CHILDREN:

NAME_____ BIRTHDATE M/F SOC. SEC.#_____

NAME_____ BIRTHDATE M/F SOC. SEC.#_____

NAME_____ BIRTHDATE M/F SOC. SEC.#_____

RESPONSIBLE PARTY *IF OTHER THAN YOURSELF*_____

RELATIONSHIP TO CLIENT:

INSURANCE INFORMATION: *(Please be sure to bring a copy of front and back of insurance card to 1st appointment)*

IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING COPAY AMOUNT AND AUTHORIZATION REQUIREMENTS.

PRIMARY INSURANCE:

INSURED'S NAME _____

RELATIONSHIP TO CLIENT:

INSURANCE COMPANY _____

POLICY/GROUP NO_____.

INSURANCE BILLING ADDRESS _____

_____

INSURED'S I.D. NO_____

INSURED.S BIRTH DATE_____

SECONDARY INSURANCE:

INSURED'S NAME _____

RELATIONSHIP TO CLIENT:

INSURANCE COMPANY _____

POLICY/GROUP NO. _____

INSURANCE BILLING ADDRESS _____

INSURED'S I.D. NO._____

INSURED.S BIRTH DATE_____

FINANCIAL RESPONSIBILITY:

I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED IRREGARDLESS OF INSURANCE COVERAGE.

X_____

Signature of Responsible Party

PLEASE COMPLETE OTHER SIDE

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM.

PLEASE DESCRIBE THE PRESENT PROBLEM:

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?

PLEASE DESCRIBE ANY HEALTH PROBLEMS.

HAVE YOU BEEN HYPNOTIZED BEFORE? ( ) YES ( ) NO / ( ) STAGE ( ) THERAPY

DO YOU SMOKE: ( )YES ( )NO SPOUSE/PARTNER: ( )YES ( )NO

DO YOU DRINK ALCOHOL? ( )YES ( )NO SPOUSE/PARTNER: ( )YES ( )NO
WHAT KIND/HOW MUCH/HOW OFTEN?_____
DO YOU USE ANY OTHER SUBSTANCES? ( )YES ( )NO
SPOUSE/PARTNER: ( )YES ( )NO
WHAT KIND/HOW MUCH/HOW OFTEN?_____
(i.e. MARIJUANA, COCAINE, ETC.)
ARE YOU TAKING ANY MEDICATION? ( )YES ( )NO
SPOUSE/PARTNER: ( )YES ( )NO
DESCRIBE_____
DO YOU HAVE ANY TROUBLE SLEEPING?( )YES ( )NO
SPOUSE/PARTNER: ( )YES ( ) NO
DESCRIBE_____
RECENTLY GAINED ( ) OR LOST ( ) WEIGHT?
HOW MUCH/OVER HOW LONG?_____ / _____
ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS? ( )YES ( )NO
DESCRIBE_____
_____
NAME OF PHYSICIAN_____ Ph# _____
DATE OF LAST PHYSICAL EXAM_____

Will you allow Kipp D. Trembley MA to utilize your sessions in a classroom setting for educational purposes or to use in published articles or books, providing your identity is kept strictly confidential?

Yes_____ No_____