Reflections Counseling
2955 McKinley Highway, Suite C, South Bend IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

Registration Information

Today's date _____

Sex: Male Female

Client's Last Name | First Name | Middle Initial

Social Security # | Birthdate | Age

Street Address | City | State | Zip Code

Home Phone | Cell Phone | E-mail Address

Employer | Occupation

Name of Primary Care Doctor | Phone # | Fax #

Primary Care Doctor Address | City | State | Zip Code

What Brings You In

Below are problems that some people face. Please circle those that pertain to you.

Suicidal Thoughts	Cutting/Burning Self	Obsessions
Excessive Worrying	Drug/Alcohol Use	Mood Swings
Nervousness	Work Trouble	Impulse Control
Panic Attacks	Relationship Trouble	Parenting Struggles
Shyness	Trauma	Hallucinations
Stress	Eating Problems	Physical Health Problems
Depression	Sleep Problems	Anger/Irritability
Concentration	Fears	Hyperactivity
Motivation	Finances	Physical/Sexual Abuse

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Have you had counseling before? Yes No

If yes, when? _____

Who was your counselor? _____

Do you see a psychiatrist? Yes No

If yes, what is your psychiatrist's name? _____

Please list any medications you are taking: _____

How would you rate your overall health? 1 2 3 4 5
Poor Neutral Excellent

How often do you drink alcohol? _____ times per month

How many drinks do you typically have in one sitting? _____

Do you use any other drugs (marijuana, cocaine, prescription medications that aren't yours)?

Yes No

If yes, what do you use and how often? _____

Marital Status: single / married / separated / divorced / widowed / significant other

Please list some of the important people in your life:

Name Relationship to you

How did you find out about our practice? _____

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Emergency Contact Information

Emergency Contact Person | Phone # | Alternate Phone #

Relationship to Client

Insurance Information

In order for us to file bills with your insurance you must complete all of the following information. Your signature and initials are required at the end of this section. We will also need a copy of your insurance card(s).

Policyholder's name | Policyholder's birthdate

Insurance Company Name | Phone # for mental health pre-certification

Identification # | Group #

Policyholder's employer | Client's relationship to Policyholder

Name of EAP (if relevant) | Authorization # | # of Sessions Authorized

_____ (initial) I understand the certain information about me can be released to insurance companies in order to process claims.

_____ (initial) I authorize payment of medical benefits to the provider for mental health services delivered

_____ (initial) I understand that co-pays are due at the time of service

_____ (initial) I understand that I am financially responsible for services rendered that are not covered by the above-mentioned insurance company

I hereby give permission to Reflections Counseling to provide me with mental health services within the scope of the provider's license and training.

Client or Parent/Guardian's signature | date