



812 W. 8<sup>th</sup> Street, Suite 6A • Plainview, Texas 79072 • [www.crossroadsmentalhealthservices.com](http://www.crossroadsmentalhealthservices.com)

## Client Information

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ DOB: \_\_\_\_\_  
Gender:  Male  Female Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
May we:  Leave a voicemail?  Text Message?  Email? (Email communication is a non-secure form of communication; we will not disclose names or identifying information.)  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Relationship Status: \_\_\_\_\_  
In case of emergency, whom should we contact? Name/Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Have you ever been treated by a therapist, counselor, psychologist or psychiatrist?  Yes  No Provider(s) and approximate dates: \_\_\_\_\_

Briefly state your current need for counseling: \_\_\_\_\_

## Medical Information

Primary Care Physician: \_\_\_\_\_  
Are you currently taking any regularly prescribed medications?  Yes  No If yes, who is the Prescriber? \_\_\_\_\_  
Please list the medications/dosages below:

Medication Name: _____	Dose: _____	Frequency: _____
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Medication Name: _____	Dose: _____	Frequency: _____
Medication Name: _____	Dose: _____	Frequency: _____

## Parent/Legal Guardian (if applicable)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
May we:  Leave a voicemail?  Text Message?  Email? (Email communication is a non-secure form of communication; we will not disclose names or identifying information.)  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_

Others living in your household?

Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____
Name: _____	DOB: _____	Relationship: _____

Who referred you to this practice? \_\_\_\_\_ May we thank them for the referral?  Yes  No  
Would you like to receive email reminders for your appointments?  Yes  No  
Would you like to receive text message reminders for your appointments?  Yes  No