CBC
Chicago Behavioral Clinic

CLIENT INFORMATION FORM

Date:_____

IDENTIFYING INFORMATION:

Name:_____ Date of Birth:_____Age:_____

Social Security #:_____

Home street address: _____ Apt/Unit #: _____

City: _____ State:_____ Zip: _____

Home phone #: _____ Ok to leave message? ☐ Yes ☐ No
Cell phone #: _____ Ok to leave message? ☐ Yes ☐ No
E-mail: _____ Ok to email? ☐ Yes ☐ No
*Calls or e-mail will be discreet, but please indicate any restrictions:
_____

CURRENT EMPLOYER:

Employer:_____ Address:_____

Work phone #: _____ Ok to leave message? ☐ Yes ☐ No

*Calls will be discreet, but please indicate any restrictions: _____
_____

EMERGENCY CONTACT:

Name:_____ Relationship: _____ Phone #: _____

VISIT INFORMATION:

Please describe the main issues that have brought you in to see me:
_____
_____

MEDICAL TREATMENT:

Clinic/Doctor's Name: _____ Phone #: _____

Address: _____

Are you dealing with any acute or chronic medical illnesses? ☐ Yes ☐ No
If yes, please explain: _____
_____

Are you taking any medications? ☐ Yes ☐ No
If yes, please list: _____
_____

TREATMENT HISTORY:

Are you currently in treatment with another mental health provider? □ Yes □ No
If yes, Provider's Name and Number?_____
Have you ever had counseling or psychological treatment? □ Yes □ No
If yes, Provider's Name and Number?_____
Do you have a psychiatrist? □ Yes □ No
If yes, Provider's Name and Number?_____

SOCIAL HISTORY:

□ Single/Never Married □ Married □ Separated
□ Divorced □ Partnered □ Widowed

Children: □ Yes □ No

If yes: Name Age Live with you?

_____

_____

LEGAL HISTORY:

Is your reason for coming related to an accident or injury? □ Yes □ No
If yes, please explain: _____
Are you currently in litigation? □ Yes □ No
If yes, please explain: _____
Have you ever been convicted of a crime? □ Yes □ No
If yes, please explain: _____
Have you ever been arrested or in prison? □ Yes □ No
If yes, please explain: _____

INSURANCE INFORMATION (*Blue Cross Blue Shield Only*)

Plan ID:_____ Group #: _____
Effective Date: _____ Employer of Cardholder:_____
Primary Cardholder Name:_____ Relation (if not self):_____
Date of Birth of Cardholder: _____ Phone # on back of card:_____

REFERRAL INFORMATION:

From whom/where were you referred for services? _____

Name: _____ Address:_____ Phone #: _____

May I have your permission to thank this person for the referral? □ Yes □ No