IVY COUNSELING GROUP

NURTURING INTERNAL RESILIENCE & STRENGTH

CLIENT HEALTH INFORMATION

182 Tamarack Circle • Skillman • New Jersey • 08558-2021 • 609-688-8300 • www.IvyCounseling Group.com

Name *(Last, First, M.I.):*	☐ M ☐ F	**Date of Birth:**	
Address:			
City:	**State:**	**Zip:**	
Email:	**Would you like to be on our mailing list?** ☐ Y ☐ N		
Phone: (H)	**(W)**	**(Cell)**	
Employer:	**Occupation:**		
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Spouse/Partner:	☐ M ☐ F	**Age:**	**Date of Birth:**
Child:	☐ M ☐ F	**Age:**	
Child:	☐ M ☐ F	**Age:**	
Child:	☐ M ☐ F	**Age:**	
Child:	☐ M ☐ F	**Age:**	
Emergency Contact:	**Relationship:**	**Cell:** **Home Phone:**	
Previous or referring healthcare provider:	**Date of last physical exam:**		
Primary Physician:	**Phone:**		
Primary Physician Address:			
Clients primary reason for visit and your expectations:			
How did you hear about our center?			

BILLING INFORMATION

Person responsible for bill (if not the patient):			
Birth date:	Home phone :	Cell phone:	
Address (if different):	City:	State:	Zip:

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Is this patient covered by insurance?	❑ Yes ❑ No		
Primary Insurance Provider:		Type of Insurance Plan:	
Subscriber's name:			Birth date:
Policy/ID #:	Group #:		
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Subscriber's Occupation:	Employer:		
Employer address:			Employer phone:
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Complaints/Concerns

What do you hope to achieve in your visit with us? ________________________________

____

If you had a magic wand and could erase three problems, what would they be?

1.
2.
3.

What was the last time you felt well? ________________________________

____

Did something trigger your change in health? ________________________________

____

What makes you feel worse? ________________________________

____

What makes you feel better? ________________________________

____

Please list current and ongoing problems in order of priority.

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success		
					Excellent	Good	Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		