Anne Rafal Counseling

228 Glenleigh Rd, Charlottesville, VA 22911
Phone 703-635-2820 Fax 703-635-7822
anne@annerafal.com
www.annerafal.com

Today's Date _____/_____/_____

CLIENT INFORMATION

Client's Last Name	First	Middle	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other

If this not your legal name what is your legal name:	Former Name	Birth Date/Age /	Gender	Preferred Pronoun

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation/Student/Retired	Employer/School	Work Phone No. ( )

Referred by: ☐ Dr. _____ ☐ Website _____ ☐ Directory _____

☐ Family ☐ Friend ☐ Close to Home/Work ☐ Insurance Plan

Email Address:	Alternative Email Address:

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )

Email Address:	Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? Yes No | Is this an EAP visit? Yes No | Total Annual EAPs allowed? _____

What is exact name of insurance?

What is the authorization number? | Self Pay

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured Self Spouse Child Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

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Please answer the following questions that may be relevant to therapy:
Please note: information you provide here is protected as confidential information.

1. Do you have any medical conditions being treated by a physician? ____yes ____no
   If yes, please note condition and dates of treatment.

2. Are you currently taking medication? ____yes ____no
   If yes, please specify type and dosage.

3. Have you previously attended therapy sessions? ____yes _____no
   If yes, when? And for how long?

4. Do you have any history of suicidal ideation or suicide attempt? ____yes ____no
   If yes, please explain.

5. Are you currently experiencing overwhelming sadness, grief or depression? ____yes ____no
   If yes, please describe and for how long.

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ____yes ____no
   If yes, please describe and for how long.

7. How often do you drink alcohol/week (including beer and wine)?

8. How often do you engage in recreational drug use?

9. What significant life changes or stressful events have you experienced recently?

10. What else would you like me to know about you?