Center For Positive Change

205 Commerce Dr., Suite C. Grayslake, IL 60030
128 Newberry Ave., Libertyville, IL 60048
Jon Cole, Ph.D. - (847) 529-0558
Andrew Hoffman, Psy.D. - (847) 409-6932

Client Information

Instructions: Please fill out this form as completely as possible and please print or write legibly. For couples and family therapy, each person should complete a set of all four pages. Please bring all completed forms with you to your first session. If you have questions or concerns about any items, please discuss them with Dr. Cole or Dr. Hoffman.

Your Name (First, Middle Initial, Last)____

Address____

City/State/Zip____

Phone #s: Home ____________________________ **Work** ______________________________

Cell ______________________________

If you do not want us to call you or leave messages for you at any of your phone #s, please write your specific preferences here:

____

Age_________ **Birth Date**___________________________

Occupation_________________________ **Employer**_________________________________

Single____ **Married**____ **(# years**_______**)** **Partnered**____ **(# years**_______**)**

Separated____ **Divorced**____ **Widowed**____

Names and ages of children____

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Spouse's/Partner's Name____ **Age**________

Spouse's/Partner's Occupation____

Significant medical problems you have or had____

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Current medications you are taking____

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If you have had any previous mental health and/or substance abuse treatment (outpatient or inpatient), list the type and approximate start and end dates for each:

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If you are currently working with any mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

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If any other household or immediate family members are currently working with any mental health professionals, list which family members and what type of professional they are working with:

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Primary Insurance Information

Insurance Company and Type (HMO, PPO, etc.)____

Member ID #________________________________ Group/Plan#_____________________________

Insurance Phone # (for benefit or claims information from your card)__________________________

Claims address (from your card)____

____

Are you the policy holder? Yes___ No___ If no, complete the following about the policy holder:

Policy holder's name____

Address & Phone # (only if different than yours)_____________________________________

____

Birth Date__________________________

Employer____

Your relationship to policy holder____

Secondary Insurance Information

Insurance Company and Type (HMO, PPO, etc.)____

Member ID #________________________________ Group/Plan#_____________________________

Insurance Phone # (for benefit or claims information from your card)__________________________

Claims address (from your card)____

____

Are you the policy holder? Yes___ No___ If no, complete the following about the policy holder:

Policy holder's name____

Address & Phone # (only if different than yours)_____________________________________

____

Birth Date__________________________

Employer____

Your relationship to policy holder____

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge.

____ ______________________________

Client Signature **Date**

CLIENTS USING INSURANCE ALSO SIGN IN BOTH PLACES BELOW

I authorize the release of any clinical, benefits or other information between Jon Cole, Ph.D. or Andrew Hoffman, Psy.D. / Center For Positive Change, P.C. and my insurance company/companies that is necessary to process insurance claims for me or my dependents. Clinical information may include current and/or past symptoms, previous mental health treatment, diagnosis/diagnoses, treatment plan and/or goals, progress reports, copies of clinical notes or other clinical information.

____ ______________________________

Client Signature (or Parent/Guardian Signature for Minors) **Date**

I authorize payment of health insurance benefits to Jon Cole, Ph.D. or Andrew Hoffman, Psy.D. / Center For Positive Change, P.C. for services provided.

____ ______________________________

Client Signature (or Parent/Guardian Signature for Minors) **Date**