"Rediscover Your True Nature"

WELCOME

Janel Volk Hubbard M.Ed., LPCC, OTR/L
Licensed Professional Clinical Counselor and Occupational Therapist

Please complete the following information and print clearly.

Janel Volk Hubbard, LLC

CLIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

How would you like to be addressed? _____

Home Address _____ City _____ Zip Code _____

Home Phone (_____) _____-_____ Cell/Alternate Home Phone (_____) _____-_____

Days & Time Generally at Home: Days _____ Times _____ Email _____

Employer _____ Occupation _____

Work Address _____ City _____ Zip Code _____

Work Phone (_____) _____-_____ Ext. _____ Days & Time at Work: Days _____ Times _____

Date of Birth ____/____/____ Age ____ Sex: Male Female Social Security Number _____-_____-_____

Relationship Status:
Single ____ Married ____ In a Committed Relationship ____ Widowed ____ Divorced ____ Separated ____

RESPONSIBLE PARTY FOR PAYING THE FEE Same as above _____

If responsible party is not the same as above, please complete this section for the responsible party.

Last Name _____ First Name _____ Middle Initial _____

Home Address _____ City _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Ext. _____

Relationship to the client: Partner Parent Other _____ Social Security Number _____-_____-_____

REFERRED BY

Last Name _____ First Name _____

Address _____ City _____ Zip Code _____

Phone (_____) _____-_____ May we thank the referral? Yes No Please Initial _____

INSURANCE INFORMATION

Insurance Company Name _____ Phone (_____) _____-_____

Address to Submit Claims _____ City_____ ___ St_____ Zip_____

Contact Person at Insurance Company _____ Group No _____

Subscriber's Last Name _____ First _____ MI _____

Subscriber's Address _____ City_____ ___ St_____ Zip_____

Subscriber's Employer _____ Work Phone (_____) _____-_____ Ext. _____

Subscriber's ID _____ Client's Relationship to Subscriber _____

ADDITIONAL CLIENT INFORMATION

Please Fill in the Blanks for all Persons Living with the Client

NAME	AGE	RELATIONSHIP

When Was Your Last Medical Checkup? _____ Who is Your Primary Care Doctor? _____

Please Describe Your Caffeine Intake _____ If You Smoke, How Much? _____

If You Are Taking Any Medications, Herbs Or Supplements, Please Fill Out The Following Chart:

MEDICATIONS HERBS/SUPPLEMENTS	DOSAGE (Amt. & Time)	STARTED WHEN?	TAKING FOR WHAT PURPOSE	PRESCRIBING DOCTOR

IN CASE OF AN EMERGENCY, WHO SHOULD BE CONTACTED?

Name _____ Relationship _____