

**Center For Positive Change**  
205 Commerce Dr., Suite C. Grayslake, IL 60030  
128 Newberry Ave., Libertyville, IL 60048  
Jon Cole, Ph.D. - (847) 548-5678  
Andrew Hoffman, Psy.D. - (847) 522-7521

**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 \_\_\_\_\_

\_\_\_\_\_

Spouse's/Partner's Name \_\_\_\_\_ Age \_\_\_\_\_

Spouse's/Partner's Occupation \_\_\_\_\_

Significant medical problems you have or had \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications you are taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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