ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

Toll Free: 800-681-2374 **Mailing Address:** PO Box 959, Stevens Point, WI 54481 **Fax:** 715-952-4995
Email: office@advocatepsychotherapyservices.com **Website:** www.advocatepsychotherapyservices.com

WALK IN CLIENT DATA SHEET

Client Name:_____ **DOB**:_____ **Age**:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell #:_____ Email:_____ School (if applicable):_____

Emergency Contact:_____ Phone #: _____

Place of Employment:_____ Marital Status (if applicable):_____

Education:_____ APS Therapist (if applicable): _____

Do you have insurance? Y N If so, which one (*and have your card ready to copy)*: _____

Payment made by: Cash Card

How did you hear about our walk-in clinic? _____

Household Members:

Name	Age	Relationship to You

Medication(s):

Medication Name	Dosage/Time	Reason	Prescribing Physician	Currently Taking

Past Behavioral Healthcare Services:

Name of Therapist/Agency	Date of Services	Reason for Services

(Over)

Presenting Problem (Current Situation and History)

A. Marriage or Relationship
B. Depression
C. Anxiety or Worry
D. Alcohol and/or Drug Use
E. Physical Problems
F. Legal Issues
G. Eating Disorder
H. Problems with Children
I. Work Related
J. Abuse or Trauma
K. Sexual Functioning
L. Financial
M. Other (please explain)

_____

_____

How long have you had this problem(s)?_____

Have you received treatment for this problem: Yes_____ No_____

Desired Topic for Help

Please identify the issue(s) you want to talk about today – and work on with a therapist as follow up.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

_____ _____

Client Signature Date

I have been given the following two forms:

1. **Informed Consent for Advocate Psychotherapy Services** ☐ Please check the box.
2. **Privacy Practices for Advocate Psychotherapy Services** ☐ Please check the box.
3. **Client Rights for Advocate Psychotherapy Services** ☐ Please check the box.

_____ _____

Client Signature Date

Follow Up Therapist at APS Identified: _____ Appointment Scheduled: _____