

Employment Status:

- 1. Employed full-time
- 2. Employed part-time
- 3. Unemployed
- 4. Full-time homemaker
- 5. Retired
- 6. Full-time student
- 7. Part-time student
- 8. Other _____

Place of Employment: _____ Occupation: _____

Please List All Household Members

Name:	Age:	D.O.B.	Relationship:
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

Medical History

Currently under Doctor's care: Yes No

Doctors involved in your care/child's care (use reverse side if necessary): _____

Health Problems (include allergies): _____

Medication currently used: NONE

Medication	Dosage	Prescribing Doctor	Reason prescribed
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations:

Date(s)	Reason(s)	Hospital
_____	_____	_____
_____	_____	_____

Previous Counseling, Psychiatric Services or Chemical Dependency Services

Counselor/Facility Name	Date(s)	Reason(s)	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____

Consent for Release of Information

I _____, hereby authorize and give permission for LIFEWAY COUNSELING CENTER to seek / release confidential information from / to

for the following purpose(s):

I understand that the exchange of this information is necessary for the treatment I am / my child is receiving. I further understand that all information I authorize to be released will be held strictly confidential within the limits of the law and cannot be released further without my permission.

I may at anytime in writing, request that this release of information be terminated. Unless otherwise specified, this release of information will be in effect until (**choose one option below**):

- _____ 90 days after last appointment
- _____ 90 days from today
- _____ Other time limit (specify below)
- _____

Printed Name of Client or Parent / Guardian

Witness

Signature

Signature

Date