

Jessica Acker LPC Inc.  
12321 Tierra Humeda  
El Paso, Tx 79938  
(915) 691-7130 call or text

**Brief Medical History and Release**

Primary Care Physician/Pediatrician Name:

\_\_\_\_\_

Physician address or phone number: \_\_\_\_\_

May we contact your Primary Care Physician/Pediatrician regarding your rehabilitation

Yes \_\_\_\_\_ No \_\_\_\_\_

Last Medical Exam: \_\_\_\_\_

List any medical problems that you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

List any prescribed medications you are currently taking: \_\_\_\_\_

Who prescribed the medications you are taking now? \_\_\_\_\_

\_\_\_\_\_

Have you seen a psychiatrist or counselor before? \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_

What accomplished? \_\_\_\_\_

Previous hospitalizations? Yes \_\_\_\_\_ No \_\_\_\_\_ Number of hospitalizations \_\_\_\_\_

When?/Where? \_\_\_\_\_

Insurance companies require that we ask you if you have any other insurance in the past 12 months.

If yes, please give the following: \_\_\_\_\_

Name of the insurance : \_\_\_\_\_

Member ID: \_\_\_\_\_

Group Number: \_\_\_\_\_

Number to reach insurance \_\_\_\_\_

**All insurance companies require authorization before we see the patient/client. It is the patient's responsibility to let our office staff know if there have been any changes to their insurance coverage. Failure to let us know will result in patient/client being rescheduled or paying for the service in full.**

Client or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_