

CLIENT INFORMATION

PRIMARY CLIENT

PARENT/SPOUSE

Name _____

Name _____

Address _____

Address _____

City/State/Zip _____

City/State _____

HM _____ WK _____ C _____

HM _____ WK _____ C _____

E-mail address _____ Is this a good way to contact you? _____

Insurance Provider _____

Insurance Provider _____

Insurance ID Number _____

Insurance ID Number _____

Marital Status: S M WID SEP DIV

Marital Status: S M WID SEP DIV

Sex: M F

Sex: M F

Employer/Grade _____

Employer/Grade _____

Date of Birth _____

Date of Birth _____

SS# _____

SS# _____

Are there special instructions about contacting you at home or work? _____

Please list others living in your home

Name

Age

Relationship

Name	Age	Relationship

How were you referred here? _____ Is it ok if I thank them for the referral? _____

Have you had previous counseling? _____ If so, when & with whom _____

Physician _____ Medications _____

Church Affiliation _____

What is bringing you to counseling at this time? _____
