Client Information—ADULT

Client's Information

Name: _____
(Last) (First) (Middle Initial)

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone:_____ Work Phone: _____ Other/Cell: _____

Date of Birth: _____ Sex: Female Male Social Security Number: _____

Employer & Occupation: _____

Other Household Members (names and ages): _____
_____
_____

Emergency Contact (name, relationship, and phone number): _____
_____
_____

Who referred you to us? _____ May we thank them? Yes No

Type of Service(s) Requested:
- ❑ Individual Psychotherapy
- ❑ Couples/Marital/Family Therapy
- ❑ Psychological Evaluation
- ❑ Substance Abuse Evaluation
- ❑ Group Therapy

Medical Information

Primary Care Physician: _____ Phone Number: _____

Address: _____
(Street) (City) (State) (Zip Code)

Medical Information (list any illnesses, injuries, conditions): _____
_____
_____

Medications (name and dosage): _____
_____
_____

Client Information—ADULT

Client's Name: _____

Insurance Information

This section must be filled out by the insured

Primary

Name of Insured and relationship to the client: _____

Insured's Address: _____

Insured's Home Phone: _____ Work Phone: _____ Other Phone: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

Insured's Employer: _____ Occupation: _____

Insurance Company: _____ Insured's ID: _____

Plan/Program Name: _____ Group, Policy, or FECA Number: _____

Secondary (if applicable)

Name of Insured and relationship to the client: _____

Insured's Address: _____

Insured's Home Phone: _____ Work Phone: _____ Other Phone: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

Insured's Employer: _____ Occupation: _____

Insurance Company: _____ Insured's ID: _____

Plan/Program Name: _____ Group, Policy, or FECA Number: _____