

CLIENT INFORMATION SHEET

Client's Name _____	Date of Birth _____		
Address			
Street : _____ Unit/Apartment Number _____			
City _____ State _____ Zip _____			
Reason for seeking services _____	Date of First Visit _____		
Phone Numbers () _____ Home Best Times to Call _____ () _____ Cell Best Times to Call _____ () _____ Work Best Times to Call _____			
Please initial acceptable ways to communicate: _____ Voice message _____ Text Message _____ Other: _____			
Family Members			
Name	Relationship	Birth date	Living in Your Home
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Primary Insurance Coverage _____ Yes _____ No			
Name of Insured _____ Insured's Date of Birth _____			
Employer _____			
Group Number _____ ID Number _____			
Relationship to Insured: _____ Self _____ Spouse _____ Child / _____ Copy of Insurance card on file			
Summary of Coverage			
Type of Insurance _____ Deductible _____ Co-Pay _____			
Visits Allowed Per Year _____ Pre-Approval Required _____			
Other Information _____			
Signature of Insured (Giving Permission to Bill) _____			
OFFICE USE ONLY			
DC(s) _____		PC(s) _____	

Secondary Insurance Coverage _____ Yes _____ No

Name of Insured _____ Insured's Date of Birth _____

Employer _____ Social Security Number _____

Group Number _____ ID Number _____

Relationship to Insured: _____ Self _____ Spouse _____ Child / _____ Copy of Insurance card on file

Summary of Coverage

Type of Insurance _____ Deductible _____ Co-Pay _____

Visits Allowed Per Year _____ Pre-Approval Required _____

Other Information _____

Signature of Insured (Giving Permission to Bill) _____

Persons Requiring Consultation / Communication with the Counselor

Permission to Contact	Title	Name	Address	Phone Number(s)
	Probation Officer			
	Physician			
	Psychologist			
	Educator/School Representative			
	Lawyer			
	Other:			

_____ Signature giving permission to contact all initialed persons named above

Medications

Medications	Condition/Reason for Taking	Dosage

Previous Counseling / Mental health Services:

Medical Conditions:

HIPA Information Provided	
Confidentiality Explained	
Received Fee Schedule	

Revised 6/2019