CONFIDENTIAL CLIENT INFORMATION

DATE: _____

CLIENT NAME: _____ GENDER: _____

STREET ADDRESS: _____ HOME PHONE: _____

CITY, STATE, ZIP CODE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ AGE: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

ADDRESS (IF DIFFERENT): _____ PHONE: _____

INSURANCE CARRIER: _____ SUBSCRIBER NAME: _____

INSURANCE ADDRESS: _____ INSURANCE PHONE: _____

SUBCRIBER ID #: _____ GROUP #: _____ SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER EMPLOYER: _____

REFERRED BY: ☐ Google Search ☐ WMHCA.org ☐ PsychologyToday.com ☐ Physician_____
☐ Insurance Provider List ☐ GoodTherapy.com ☐ Other_____

MEDICAL INFORMATION

CURRENT MEDICAL CONDITIONS: _____

_____

CURRENT MEDICATIONS: _____

DO YOU USE ALCOHOL? _____ AMOUNT/HOW OFTEN? _____

DO YOU USE DRUGS? _____ WHAT/HOW OFTEN? _____

DURING THE PAST YEAR HAVE YOU FELT SUICIDAL? _____ YES: _____ NO: _____

HAVE YOU HAD PREVIOUS COUNSELING? _____ NAME OF THERAPIST: _____

WHAT WERE YOU SEEN FOR: _____

REASON FOR SEEKING COUNSELING TODAY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

OTHERS LIVING IN YOUR HOME:

NAME	RELATIONSHIP	AGE	SCHOOL YEAR/OCCUPATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____