CLIENT INFORMATION SHEET

Date of intake:_____/_____/_____

Name _____ Date of birth _____/_____/_____ Age_____

Client Social Security #: _____Sex: Male/ Female Race/Ethnicity (optional) _____

Marital Status: Single Married Separated Divorced

Address _____

City/State/Zip _____ Home Phone _____

Email Address_____ Cell/Work Phone _____

Occupation _____Employers Name: _____

Name of your Primary Care Physician _____
PCP Phone: _____ PCP Fax_____

Referred By: (please circle) Physician Yellow Pages Friend/Family Other_____

May I contact or leave messages for the client or parent/Legal Guardian at the numbers listed above? Yes / No

If Client is under age 18 Please provide the Name of Parent/Legal Guardian Bringing Child to Appointment:
_____

Insurance Information

Insurance Company Name: _____Phone # for Mental Health Benefits/Services: _____

Policyholder's Name: _____ Date of Birth: ____ /____/____ Sex: M / F

Policyholder's Address: _____

Policyholder's SSN: _____ Marital Status: _____

Member ID Number/Medicaid#: _____ Group/Plan/Policy#_____

Authorization for services may be required prior to treatment. Did you obtain authorization for services from your insurance company? Yes / No / Not required Authorization #: _____# of sessions approved ___

Policyholders' Employer (Name & Address) _____
_____

Other people living in the home:

Name	Age	Relationship to Client

Emergency Contact: _____ Relationship_____
Complete Address: _____
Home Phone: _____Work Phone: _____ Cell Phone: _____
Spouse's Name (If not Emergency Contact): _____
Home Phone: _____Work Phone: _____Cell Phone:_____