Client Information Sheet

Personal Information

Full Name _____

Address _____

_____

_____

DOB: _____ Age: _____

Phone/Cell _____

E-mail _____

Marital Status:
__Single__ Mar__ Sep__ Div__Wid_ CoHab

Employment: Yes/No/Disabled/Student

Employer: _____

Occupation: _____

Emergency Contact

Name _____

Relationship: _____

Contact Number: _____

Medical/Insurance Information

Primary Care or Psychiatrist: _____

Address _____

_____

_____

Phone: _____

Date of Last Visit: _____

Significant Current Medical Concerns:

_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____

PRIMARY INSURANCE:

Insurance Company: _____

Name of Insured: _____

Insured ID: _____

Plan Number: _____

Policy Number: _____

Group Number: _____

Payer Number: _____

SECONDARY INSURANCE (IF ANY)

Insurance Company: _____

Name of Insured: _____

Insured ID: _____

Plan Number: _____

Policy Number: _____

Group Number: _____

Payer Number: _____

Alcohol Dependence _____ Self Esteem _____
Anger Management _____ Sleep Issues _____
Anxiety/Depression _____ Fears/Phobias _____
Other: _____

Smoking Cessation ____ Weight Loss _____
Stress Management ____ Relationship Issues _____
Life Transitions/Loss _____