Client Information Form

☐ **New Client** ☐ **Updated Information** ☐ **Adult** ☐ **Child**

Therapist: _____ **Date:** _____

Client's Name: _____ D.O.B. _____

Address: _____

City, ST, Zip_____

PH: (H) _____(W) _____ (C) _____

Employer: _____

Marital Status: _____How Long: _____ email:_____ Gender:_____

Complete ONLY if patient is a child:

School: _____

Parent/Guardian's Name: _____ Cell # _____

Employer: _____ How Long: _____

Parent/Guardian's Name: _____ Cell # _____

Employer: _____How Long:_____

Primary Ins Co. _____Phone#_ _____

Client's Membership #:_____Group #:_____

Policy Holder Information for primary insurance:

Name: _____ DOB_____

Insured's Employer: _____Relationship:_____

Secondary Ins.(if applicable)_____Phone #_____

Client's Membership #:_____ Group #:_____ _____

Policy Holder Information for secondary insurance:

Name: _____ DOB_____

Insured's Employer: _____Relationship:_____

If we are unable to contact you, please list the closest relative or friend:

Name: _____

Relationship:_____ Phone #_____

I authorize the release of any medical information necessary to process this claim, payment of medical benefits to the physician or supplier of services and the release of medical information to my primary care Physician

Client Signature_____**Date**:_____

If Minor, Guardian Signature_____ **Date:**_____

Primary Care Physician:_____ Phone # _____

DIAGNOSIS: _____Referred by_____