Adult Client Information Form

Last Name, First Name, MI: _____ Date: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Email: _____ May we email you**? ☐ Yes ☐ No

Please note: Email correspondence is **not considered to be a confidential medium of communication.

Cell Phone: (____)_____ May we leave a message? ☐ Yes ☐ No

We have permission to send appointment reminders: by email? ☐ Yes ☐ No by text? ☐ Yes ☐ No

Street Address: _____

City: _____ State: _____ Zip/Postal code: _____

Home Phone: (____)_____ May we leave a message? ☐ Yes ☐ No

Work Phone: (____)_____ May we leave a message? ☐ Yes ☐ No

Marital Status (circle one): Single / Married / Divorced / Legally Separated / Widowed

Spouse (if applicable): _____ Referred By: _____

Employment Status (circle one): Full-time / Part-time / Not Employed / Retired / Disabled / Student

Emergency Contact/Relationship: _____ Phone: (____)_____

Financially Responsible Party (if different from client): _____

Primary Insurance: _____ Subscriber ID #: _____

Group/Plan #: _____ Provider Phone Number: (_____)_____

Insurance Address: _____

City/State: _____ Zip code: _____

Employer who insurance is through: _____

Client's Relationship to Insured: _____ Insured name (if different than client): _____

Insured SSN: _____ -- _____ -- _____ Insured Date of Birth: _____/_____/_____

Insureds Address (if different) _____

Insureds Phone Number (if different) _____

Secondary Insurance: _____ Subscriber ID #: _____

Group/Plan #: _____ Provider Phone Number: (_____)_____

Insurance Address: _____

City/State: _____ Zip code: _____

Employer who insurance is through: _____

Client's Relationship to Insured: _____ Insured name: _____

Insured SSN: _____ -- _____ -- _____ Insured Date of Birth: _____/_____/_____

Name of Employer: _____ Occupation: _____

Employer Address: _____

City/State: _____ Zip code: _____

Medical Doctor: _____ Phone: (____)_____

Psychiatrist: _____ Phone: (____)_____

Have you previously received any type of mental health services (counseling, psychiatric services, etc)?

□ No □ Yes: Previous practitioner: _____

_____

Are you currently taking any psychiatric or prescription medication?

□ No □ Yes: Please list: _____

_____