New Client Information Form

Legal Name:____DOB__________________________

Parent/guardian name (if minor)____

Mailing Address:

Street____________________________________City____________________State_____Zip____________

Home Phone ________________Cell Phone ______________Email__________________(required for reminder services)

Is it okay for us to leave confidential messages on your voicemail(s)? ☐ Yes ☐ No

Current medications (if any): ____

Emergency contact ____________________________________ Phone ___________Relationship____________

Are you employed? ☐ Yes ☐ No Place of Employment____

What brings you in to counseling?

____

____

____

____

How did you hear about us?

____

======================**HEALTH INSURANCE INFORMATION**======================

Plan Name ____Provider Phone #_________________________

Group Number ______________________________ ID Number_______________________________________

Please fill out primary subscriber information, if not self:

Name________________________________ DOB_____________ Phone______________________________

Street____________________________________ City______________________ State____ Zip___________

Your relationship to Primary Subscriber: ☐ Self ☐ Spouse ☐ Dependent of

Clinician seen: ____