

CLIENT INFORMATION

Today's date _____ Birthdate _____ Age _____ Marital status _____
Name _____
Address _____ City _____ Zip _____
Home Phone_(____) _____ Work Phone_(____) _____
Cell Phone (____) _____ email _____
Emergency Contact _____ Phone_(____) _____
Your employer/occupation _____
Highest grade/degree _____ Major _____
Partner/spouse's name _____ Work phone_(____) _____
Partner/spouse's
employer/occupation _____
Children's names and ages _____
Medical insurance co. name/group number _____
Name on policy _____ I.D.# _____
Insurance Co. phone number _____
Have you ever been in counseling before? Please give approximate dates and describe
briefly: _____

Please describe any medical
problems _____
Medications _____
What are your goals for
counseling? _____

Name of person who referred you _____
May I contact them? _____yes _____ no _____

CLIENT RESPONSIBILITIES: I am expected to pay for services by the end of each session. I will be given a billing form to be sent to my insurance company for reimbursement to me. **I am personally responsible for my account. I am expected to give 24 hour advance notice if I am unable to keep an appointment. If I fail to give such notice, I will be charged in full for the time reserved.**

ABOUT PRIVILEGED INFORMATION: With a few exceptions required by law, or for my health and safety as a client, my relationship with my therapist is privileged and will be treated in a confidential manner. **No privileged information will be released without my written consent.** Some of the information therapists are mandated to report include: suspected or actual child abuse, abuse of the elderly, and threats or imminent danger to myself or others.

I certify that I have read and understand the above information and accept my responsibilities as explained.

CLIENT SIGNATURE _____