

CLIENT INFORMATION

Client Name _____ Date _____

Spouse/Parent _____ Spouse/Parent _____
 (Married, Separated, Divorced – circle one)

Address/Zip Code

Home phone / Cell / Alternate / Email

Social Security # Date of Birth

Employer

Insurance Company Phone

Authorization #

Address/Zip Code

Home phone / Cell / Alternate / Email

Social Security # Date of Birth

Employer

Insurance Company Phone

Authorization #

CHILD'S NAME	AGE	DOB	MINE / PARTNER'S / OURS ?	LIVING WITH YOU?	SCHOOL
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Previous Therapy (yes/no)?

With Whom:

Primary Physician:

Current Medications:

History of Alcohol, Drug Addiction:

Family History of Alcohol, Drug Addiction, Other Illnesses:

Do you currently attend church? Where?

How were referred to us? May we thank them for your referral?

Name

Organization