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New Client Information

Please answer the following questions to the best of your ability. If you have questions about how to answer any of them please let me know and we can discuss them in our session.

Date: _____

Last Name: _____ First Name: _____ MI: ____

Age: _____ Date of Birth: _____Preferred Gender:_____

Street Address: _____

City: _____State:_____ Zip Code: _____

Home Phone: _____ Okay to leave message? _____

Work Phone: _____ Okay to leave message? _____

Cell Phone: _____Okay to leave message? _____

Email:_____Okay to leave message? _____

Employer: _____

What kind of work do you do? _____

If in school, name of school and year of study _____

Do you have health insurance? Yes___No____

Insurance Company _____ ID # _____

In whose name is the policy?_____

If not you, policyholder name _____

Address of policy holder (if not you):

Street Address: _____

City: _____State:_____ Zip Code: _____

Home/ Cell of Policy Holder (if different from yours)_____

Policyholder date of birth _____

Policyholder place of work_____

Do you have a policy in addition to your spouse/partner? Y___ N___

Your signature allows me to submit insurance bill:_____

Name of Emergency Contact/Relationship to you: _____

Contact information: _____

Referral Source (how did you hear about me):_____
Have you ever been in therapy or counseling before? Yes____ No ____
If so, did you find it helpful? Yes____ No ____
Have you ever been hospitalized for mental health treatment? Yes____No____

If yes, when and where? _____

_____

Are you currently under the care of another mental health provider? (e.g. psychiatrist, nurse practitioner?) Yes ____No _____

Provider Name and contact: _____

_____

Please list any medications you are currently taking:

Please list any medical conditions: