



NEW CLIENT INFORMATION

Referred By: _____ Today's Date: _____

I. Client Information:

Name: _____ DOB: _____ Age: _____
Address: _____ City, State, Zip: _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Social Security #: _____ Male Female
Employer: _____ Job Title: _____
In case of emergency, please notify:

Name _____ Ph: _____ Relationship: _____

Please complete this section for others residing in the client's home:

Name	Date of Birth	Age	Gender	Relationship To Patient

II. Insurance:

Policy Holder's Name: _____ DOB: _____ Age: _____
Address: _____ City, State, Zip: _____
Home Ph: _____ Cell Ph: _____ Work Ph: _____
Social Security #: _____ Male Female

Insurance or EAP Company: _____ Policy Holder/Subscriber ID# _____
Address: _____ City, State, Zip: _____
Authorization #: _____ Number of Sessions Authorized: _____ Co-pay: _____
Employer: _____ Job Title: _____
If patient is a dependent, what is his / her relationship to policyholder: _____

Please provide your insurance card to make a copy for your record.

III. Optional Information:

Ethnic Background:

- American Indian or Alaskan Native
- Asian or Pacific Islander
- African-American
- Hispanic
- Caucasian
- Other: _____

Highest Education Level:

- No High School
- Some High School
- High School Diploma
- Some College / Technical School
- Associate's Degree
- Bachelor's Degree
- Master's Degree

