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Client Information Form

Name: _____ Date: _____
Name on Insurance Card (if different than above): _____
Address: _____
Phone: _____ Email: _____ Age: _____
Date of Birth: _____ Gender Identity: _____ Pronouns: _____
Gender listed on insurance (if different than above): _____
Occupation or Grade (and school name): _____

Primary Insurance: _____ Subscriber: _____
ID#: _____ Group#: _____ Phone: _____
Secondary Insurance: _____

Marital Status: ___ Single ___ Married ___ Divorced/Separated ___ Widowed ___ Living w/ someone
Children (Names/Ages): _____

Name of Primary Care Physician: _____
Physician's Address: _____ Physician's Phone: _____
*Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO
Please sign here for either answer: _____
Current Medications being taken:
1) _____ Dosage/Frequency _____ Purpose _____
2) _____ Dosage/Frequency _____ Purpose _____
3) _____ Dosage/Frequency _____ Purpose _____
4) _____ Dosage/Frequency _____ Purpose _____