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Client's Name: ____ Date: ______________

Client's Address: ____________________________ City: ____________ State: ___ Zip: _______

Phone: (Home) ___________ (Mobile) ___________ (Work) ___________

Date of Birth: ___________ SSN: ___________Occupation/School:______________ Grade:______

Single☐ Married☐ Separated☐ Divorced☐ Widowed☐ Employed☐ Student ☐

Spouse/Partner's name: ______________________________ DOB: _____________

Spouse/Partner's name: ______________________________ DOB: _____________

Spouse/Partner's Phone: ______________________________

Name(s) and age(s) of Children/Siblings: Living with you? Name(s) and age(s) of Children/Siblings: Living with you?

___________________ _____ Yes☐ No☐ ______________________ ___ Yes☐ No☐

___________________ _____ Yes☐ No☐ ______________________ ___ Yes☐ No☐

___________________ _____ Yes☐ No☐ ______________________ ___ Yes☐ No☐

Others living with you: ____

Medical Information:

Please describe any medical problems: ____

Current medications: ____

Insurance/EAP Information:

Insured's Name: ______________________________ Date of Birth: ___________

Insured's Address _______________________ City: ________ State: ___ Zip: _____

Insured's Phone: (Home) _________ (Mobile)__________ Insured's SSN: ____ ___ ____

Client's Relationship to the Insured**:** Self ☐ Spouse ☐ Child ☐ Other ☐

Name of Insurance Plan: ____

Insured's Policy Group Number:______________ Member ID Number________________

Insured's Employer: ________________ Insurance Mental Health Phone # (800)___________

Is there a second health insurance plan? Yes☐ No☐

If yes: Other Insured's Name: ____________________________ ____________

Last Name First Name Middle Date of Birth

Other Insurance Plan Name: _______________ Phone: (800)_______ ID #__________