CLIENT INFORMATION FOR INDIVIDUAL THERAPY
(Please print)

DATE ____________

CLIENT INFORMATION

Last Name ____________________________________

First Name ____________________________________

Address ____________________________________

City ____________________________________

State ________________ Zip Code ________________

Home Phone (______) ______________________________

Work Phone (______) ______________________________

Cell Phone (______) ______________________________

Marital Status S M D W

Sex Female ____ Male ____

Date of Birth ____________________________________

Social Security # ____________________________________

E-Mail Address ____________________________________

POLICY HOLDER INFORMATION
(only If other than client)

Last Name ____________________________________

First Name ____________________________________

Address ____________________________________

City ____________________________________

State ________________ Zip Code ________________

Home Phone (______) ______________________________

Work Phone (______) ______________________________

Cell Phone (_______) ______________________________

Marital Status S M D W

Sex Female ____ Male ____

Date of Birth ____________________________________

Social Security # ____________________________________

E-Mail Address ____________________________________

Client Relationship to Insured (circle one) SELF SPOUSE CHILD OTHER

INSURANCE INFORMATION

Insurance Co. Name ______________________________

Insurance Co. Address ______________________________

City ____________________________________

State ________________ Zip Code ____________________

Insurance Co. Phone ______________________________

Policy Identification # ______________________________

Policy Group # ____________________________________

Policy Group Name ______________________________

Secondary Insurance Coverage YES NO

Name of Referring Physician or Friend ____

FOE OFFICE USE ONLY:

Therapist ____________________________________ TH _____________ DX____________