

Client Information

Date: _____ The person/office that refer you to us? _____
May we send them a thank you note? _____

Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work: () _____

Cell Phone : () _____ e-mail: _____ TDL# _____

What is the best way to reach you? _____

Date of Birth: _____ SSN#: _____

Sex : Female: _____ Male: _____ Marital Status: M _____ S _____ D _____

Education: _____ Employer: _____ Occupation: _____

Reason for seeking counseling: _____

Previous therapy/counseling: _____ Outcome? _____

Family Physician: _____ Overall health: _____ Date of last physical: _____

Current Medications: _____

List any Chronic health conditions: _____

List names (& age) of immediate family member (those living with you) :

INSURED or RESPONSIBLE PARTY (if other than client):

Name: _____ Relationship to client: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Work () _____

Date of Birth: _____ Social Security # : _____

Employer: _____ Occupation: _____

Insurance Company: _____ Group #: _____ ID#: _____

Claims Address: _____

Telephone # (found on your insurance I.D. card): _____

By signing this form I am authorizing Aracely Neeley, LCSW to file under my insurance plan and assigning to her benefits as provided by my plan.

Client Signature

Date