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Client Information (Adult) **Today's Date: _____/_____/_______**

Last Name _______________________First Name_________________Date of birth: _____/_____/________Age: _____

Home Address: _____________________________________City_________________ State______ Zip _____________

Contact phone number: (   ) ________-_______________ Email:_________________________@_______________

Emergency Contact: ______________________ Relationship: _______________ Phone: (   ) _______-____________

Employment Status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired [ ]Student

Occupation___________________ Employer _______________________ If student, school _______________________

Do you have a religious preference? [ ] No [ ] Yes ____

Marital Status: [ ] Never Married [ ] Married [ ] Single [ ] In Relationship [ ] Divorced [ ] Separated [ ] Widowed

Children/Age(s), if any: ____

Referred by: ____________________If no referral, how did you hear of my services? ____________________________

- **Complete this box if you are using your Employee Assistance Program (EAP):**

EAP

EAP Carrier: __________________________________ Employer ____

Name of Employee: ____ Employee's date of birth: _____/_____/_______

Your relationship to employee: [ ] Self [ ] Spouse [ ] Child

Authorization #: ______________________ Number of sessions: ________

- **Complete this box if you are using Health Insurance:**

HEALTH INSURANCE

Insurance Carrier: ______________________ Name of Insured: ____

Insurance ID #: __________________________________ Insured's date of birth: _____/_____/_______

Your relationship to insured: [] Self [] Spouse [] Child

Provider's Phone # on Ins. Card: _______-________-_______________

Are you covered by any other insurance? [] No, this is primary coverage [] Yes ___________________________

- ***I am responsible for all charges incurred.***
- ***I attest that all information provided here is true and correct.***

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Signature *Date*