



CLIENT INFORMATION FORM

Group, Family and Individual Counseling
Specializing in Child & Adolescent Neurobehavioral Disorders

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Start Date _____ Client DOB _____
Client First _____ Last _____
Address _____
Suite/Apt. _____
City _____ State _____ ZIP _____
Home Phone _____ Mobile/Cell _____
Work Phone _____ Email _____

For Office Use Only
Therapist _____
CPT _____
Diag Code _____
Session Length _____
Fee _____

Parent/Guardian Information (if client is a minor):

Form with two columns for parent/guardian information including fields for First, Last, Address, Suite/Apt., City, St, ZIP, Home, Cell, Work, Email, and Relation to Client. Includes checkboxes for 'Check if Financially Responsible for Payment'.

Please list all current household members and their ages:

Household Members

Table with 6 columns for household members and their ages.

Party to notify in case of an emergency:

Name: _____ Phone: _____ Relation to Client: _____

Referral Information (Please list all known information for us to send our thanks):

Name: _____ Referral Source: _____
Address: _____
City: _____ St _____ ZIP _____

*** Would you like a diagnosis listed on your billing statement: Yes No

*** As a fee-for-service private practice, we do not bill insurance companies for our treatment services.