



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

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CLIENT INFORMATION FORM

Date: _____

Client Name: _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Financially Responsible (if client is a minor): _____

Parent/Guardian Address(if different from above): _____

City: _____ State: _____ Zip Code: _____

Client Date of Birth: _____

Home Phone Number: _____

Mother Cell Phone: _____ Mother Work Phone: _____

Father Cell Phone: _____ Father Work Phone: _____

Parent/Guardian E-Mail Address: _____

Please list all current household members and their ages:

Party to notify in case of an emergency:

Name: _____ Phone Number: _____

Medications Client is currently taking (include dosage if known):

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*** As we are a private pay practice and do not directly bill insurance companies, please indicate if you will be submitting billing statements to your insurance company for services: YES _____ NO _____

*** Would you like a diagnosis listed on your billing statement: YES _____ NO _____