

Initial Client Information Fact Sheet

Name: _____ Birth Date: ___/___/___
Address: _____ Today's Date: ___/___/___
Employer: _____ Phone: (H): _____
Address: _____ Phone: (W): _____
Emergency Contact Name: _____ SSN: _____
Phone Number: _____ Relationship: _____
Relationship Status: ___ Married ___ Yrs. ___ Never married ___ Separated ___ Committed relationship
___ Divorced ___ Yrs. ___ Widowed ___ Yrs.
Children (Names and Ages): _____

Employer/School: _____ Length of current employment: _____
Address: _____
Occupation: _____

Responsible Parent/Guardian/Spouse Info:

Name: _____
Address/Phone: _____
Employer: _____
Who referred you to the clinic? _____
Have you been in treatment before? If so, where and when? _____
Current reason for seeking treatment: ___ AODA ___ Interpersonal
___ Academic/Career ___ Court Ordered
___ Mood ___ Referred
___ Other: _____

Insurance/Billing Information:

Primary Insurance Data:
Policy Holder: _____ Employer: _____
Insurance Company: _____
Address: _____
ID #: _____ Group #: _____
Group Name: _____ Effective Date: _____
Insurance Verification Phone: _____

Secondary Insurance Data:
Policy Holder: _____ Employer: _____
Insurance Company: _____
Address: _____
ID #: _____ Group #: _____
Group Name: _____ Effective Date: _____
Insurance Verification Phone: _____

Designated Family Physician: _____

Please print legal name clearly: _____

Signature: _____