The Next Step Counseling Services, LLC

Client Information Form

Date:_____

Name:_____ Date of Birth:_____ Age:_____
Social Security # :_____ Sex: M F Marital Status: S M D W
Home Address _____ Apt.: _____
City: _____ State: _____ Zip: _____
Home/Evening Phone _____ Cell Phone _____

Insurance Subscriber Address _____
City: _____ State: _____ Zip: _____
Insurance Subscribers DOB: _____ Insurance Subscribers Social Security # _____
Insurance Company _____Member ID:_____

Parent/Guardian Name _____
Address _____ Phone _____
Emergency Contact or Next of Kin _____
Address _____ Phone _____

For Appointment Reminders by text or email, please provide the following information:
Email Address _____
Cell Phone Number_____ Cell Phone Carrier_____

Referral: Who gave you my name to call?
Name: _____ Phone: _____
Address: _____
May I have your permission to thank this person for the referral? Yes No
How did this person explain that I might be of help to you?
_____
_____
_____

Chief concern:
Please describe the main difficulty that has brought you to see me:
_____
_____
_____

Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No