

C² Counseling
Client Information Form

Date: _____

Please fill out, circle, or check the appropriate information below.

Name: _____ Marital Status: Single/Married/Divorced/Widowed

DOB: ____ / ____ / ____ Age: _____ Social Security #: _____ Gender: Male/Female

Address: _____ City _____ State _____ Zip _____

Telephone: _____ (home/cell) _____ (work/other)

May we leave a message? Yes No

May we leave a message? Yes No

E-Mail: _____ May we email you? Yes No

Driver's License #: _____ State: _____

Employer/School: _____

Employee/School Schedule: Full Time/Part Time

Address: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Telephone: _____

If client is a minor

Relationship to child: _____ Custodial Parent: _____

Address and Telephone: _____

Name of spouse: _____

DOB: ____ / ____ / ____ Social Security #: _____ Gender: Male/Female

Address: _____ City _____ State _____ Zip _____

Employer: _____

Employee Schedule: Full Time/Part Time

Address: _____ Phone #: _____

INSURANCE

Insurance Company: _____

Policy Holder: _____

Policy/ID #: _____ Group #: _____

Policy Type: Single/Family Effective Date: _____

Second Insurance: _____

Policy/ID#: _____ Group #: _____

Did someone refer you to C2 Counseling? Yes No If yes, who: _____

Are you a returning client? Yes No If yes, when? _____

Name of Counselor(s): _____

Are you seeing any other counselor, psychologist, psychiatrist, or mental health professional? Yes No