Client Data Sheet

Today's Date ___/___/___

Name____
Last First Middle Initial

Home Address____

City, State and Zip Code____

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

E-Mail____

Social Security Number ______________ Birth Date ___/___/____ Age ____ Sex _____

***Insured________________________ Insured's Employer______________________

Billing Address (if different from above)_________________________________

Employers Name _______________________ Your Position ______________________

Address_______________________________________ Years with Employer ______

Education (# of Years)________ Highest Degree ________ Usual Occupation______________________

Referred By____

Others in your family or living in the home with you:

Name	Age	Relationship to you

In Emergency, Notify: (Please name two)

Name ______________________________ Name ______________________________
Address____________________________ Address____________________________
___________________________________ ___________________________________
Phone______________________________ Phone______________________________
Relationship to you________________ Relationship to you________________

Family Physician: ____
Name Phone

____
Address City State Zip

Your Signature____ Date____/____/___

(This signature does not authorize release of information or obligate you in any way to InSight Counseling, LLC. or your Independent Practitioner. It is requested for your protection only)

***Regarding insurance: It is the responsibility of the client to file claims with their insurance company. Your Practitioner does not maintain a supply of insurance forms. Payment is required at the time of service.