Sarah Miller LLC, LCPC
Licensed Clinical Professional Counselor
Adolescent Data Sheet

Today's Date ____/____/____

Last Name_____
Last Name First Name Middle Initial

Home Address_____

City, State and Zip Code_____

Home Phone ( ) _____Cell Phone ( ) _____ Mom Work ( ) _____
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

Mom Cell ( ) _____ Dad Work ( ) _____ Dad Cell ( ) _____
May we call there? Yes/No May we call there? Yes/No May we call there? Yes/No

E-Mail (Adolescent)_____E-Mail (Parent)_____
May we use this email for appointment reminders? Yes/No May we use this email for appointment reminders? Yes/No

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

***Insured_____ Insured's Employer_____

Responsible Party _____ DOB of Insured _____

Education (grade) _____ School _____

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., L.L.C or your Independent Practitioner. It is requested for your protection only)

Parental Consent_____Date____/____/__

***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.

InSight Counseling, LLC is home to a network of Independent Practitioners.