

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 Address Phone 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.