

Jessica Thompson, MS, RD, LD
Registered Dietitian
Client 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

Email (Adolescent) _____ Email (Parent) _____

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

***Insured _____ Insured's Employer _____

Responsible Party _____

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.