Client Information Form

_____
Date

_____ _____ _____
Last Name **First Name** **Middle**

_____ _____
Address **Date of Birth**

_____ _____
City, State Zip Code **Social Security Number**

_____ _____
Email **Phone Number**

PREFERRED METHOD OF CONTACT: Email Phone

EMERGENCY CONTACT: _____
First and Last Name

_____
Phone

CURRENT MEDICATIONS: **PRESCRIBING PHYSICIAN AND PHONE NUMBER:**

_____ _____

_____ _____

INSURANCE INFORMATION:

_____ _____ _____
Carrier **Member ID#** **Group#**

_____
Name of Primary Insurer and date of birth if different from above

SPECIAL ACCOMMODATIONS NEEDED? PLEASE DESCRIBE:

_____

REFERRAL SOURCE:

- ❑ Counseling at Dupont website
- ❑ Advertising/Postcard
- ❑ Other source _____
- ❑ Medical Provider _____
- ❑ Other therapist/community resource _____