**CLIENT FACE SHEET**

**DATE:**

**REFERRAL SOURCE:**

**THERAPIST YOU ARE REQUESTING TO SEE:**

**CLIENT NAME:**

**MALE/FEMALE:**

**DATE OF BIRTH:**

**MARITAL STATUS:**

**HOMEADDRESS:**

**WORKPLACE NAME/ ADDRESS:**

**PRIMARY INSUREDS INFORMATION**

**PRIMARY INSURED’S NAME:**

**RELATIONSHIP TO PRIMARY INSURED:**

**INSURANCE COMPANY NAME:**

**PRIMARY INSURED’S DATE OF BIRTH:**

**PRIMARY INSURED’S EMPLOYER:**

**PRIMARY INSURED’S HOME ADDRESS:**

**INSURANCE ID NUMBER:**

**INSURANCE GROUP NUMBER:**

**PHONE NUMBER ON BACK OF INSURANCE CARD (MAY SAY MENTAL HEALTH & SUBSTANCE ABUSE PROVIDERS CALL):**

**CONTACT INFORMATION**

**PERSON & PHONE NO. TO CALL IN EMERGENCY:**

**FOR CONFIDENTIAL/PRIVATE MESSAGES:**

**Phone:**

**E-mail:**

Thank You & I Look Forward to Meeting You