Phoenix
COUNSELING SERVICES, LLC

Client Name: _____ DOB: _____

New Client Information Form

Welcome to Phoenix Counseling Services, LLC. Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask!

Today's Date: _____

Full Name: _____ Age: _____ Date of Birth: _____

Address: _____
Street city state zip

Home phone: _____ Cell Phone: _____
Okay to leave messages? Y N
Circle one: Male Female Social Security Number: _____

Ethnicity: _____ Where did you grow up? _____

Emergency contact person (name, relationship): _____

Phone Number: _____

Primary Care Physician Full Name: _____

Practice Name: _____

Address: _____City: _____state: _____ Zip: _____

Client's Primary Insurance: _____ Insurance ID Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Social Security Number: _____ Relationship to policy holder: _____

Policy Holder's employer: _____ Primary Language Spoken: _____

For Mental Health Clients Under 14

Custody status (circle one): N/A Shared Joint Legal Mother Only Father Only

Parent/Guardian's Name: _____ Parent Guardian SSN: _____

State Law (ref: HB2036) requires that we ask if you have a Mental Health advance directive:
(circle one): Yes NO

A mental Health Advanced Directive is a legal document of instruction in the event of mental health incapacitation. If you have one, please provide us with a copy for in your chart.
If No, would you like us to provide you with information on how to fill one out?
(circle one) Yes No N/A