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 Legal Name: _____ Age: _____ Date of Birth: _____

Name You Go By: _____ Pronouns: _____

Address: _____
street city state zip

Home phone: _____ Cell Phone: _____
Okay to leave messages? Y N

Social Security Number: _____

Ethnicity: _____ Where did you grow up? _____
Primary Language Spoken: _____ Gender Identity: _____

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: _____

Do you have Secondary Insurance? Yes or No How did you hear about us? : _____

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