Debbie Reed, L.M.F.T.
Licensed Marriage and Family Therapist

28494 Westinghouse Place, STE 201
Valencia, CA 91355
Telephone: (661) 287-4243

ADULT CLIENT INFORMATION

YOUR NAME	DOB	SEX	AGE	MARITAL STATUS
HOME ADDRESS	CITY		STATE	ZIP
HOME PHONE #	WORK PHONE #		CELL PHONE #	
DL #	EDUCATION LEVEL		E-MAIL ADDRESS	
EMPLOYER	OCCUPATION		LENGTH OF EMPLOYMENT	
EMPLOYER'S ADDRESS	CITY		STATE	ZIP

NAME OF SPOUSE/PARTNER	DOB	SEX	AGE	MARITAL STATUS
HOME ADDRESS	CITY		STATE	ZIP
HOME PHONE #	WORK PHONE #		CELL PHONE #	
DL #	EDUCATION LEVEL		E-MAIL ADDRESS	
EMPLOYER	OCCUPATION		LENGTH OF EMPLOYMENT	
EMPLOYER'S ADDRESS	CITY		STATE	ZIP

OTHER MEMBERS OF IMMEDIATE FAMILY

NAME	AGE	RELATIONSHIP TO CLIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRIMARY INSURANCE CO.	INS. PHONE #	POLICY #	GROUP #
ADDRESS	CITY	STATE	ZIP
PRIMARY INSURED'S NAME	PRIMARY INSURED'S EMPLOYER		
PRIMARY INSURED'S SOCIAL SECURITY #	PRIMARY INSURED'S DATE OF BIRTH		

 DATE: _____

ADULT CLIENT INFORMATION (P.2)

SECONDARY INSURANCE CO.	INS. PHONE #	POLICY #	GROUP #
ADDRESS	CITY	STATE	ZIP
SECONDARY INSURED'S NAME	SECONDARY INSURED'S EMPLOYER		
SECONDARY INSURED'S SOCIAL SECURITY #	SECONDARY INSURED'S DATE OF BIRTH		

WOULD YOU LIKE A MONTHLY RECEIPT FOR YOUR THERAPY SESSIONS?
☐ NO, I DO NOT NEED A RECEIPT AS MY CANCELLED CHECK, BANK OR CREDIT CARD STATEMENT IS SUFFICIENT.
☐ YES, I WOULD LIKE A MONTHLY RECEIPT TO SUBMIT TO MY INSURANCE COMPANY FOR REIMBURSEMENT.
☐ YES, I WOULD LIKE A MONTHLY RECEIPT FOR REIMBURSEMENT FROM MY FSA/HSA.
☐ YES, I WOULD LIKE A MONTHLY RECEIPT FOR MY HOUSEHOLD RECORDS.
IF YES, WHICH E-MAIL ADDRESS WOULD YOU LIKE YOUR MONTHLY RECEIPT SENT TO? _____

REFERRED BY		CAN I SEND THIS PERSON A THANK YOU NOTE?
CONTACT IN EMERGENCY	RELATIONSHIP	PHONE #

DATE: _____