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## 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		

## 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		

<p>WOULD YOU LIKE A MONTHLY RECEIPT FOR YOUR THERAPY SESSIONS?</p> <p><input type="checkbox"/> NO, I DO NOT NEED A RECEIPT AS MY CANCELLED CHECK, BANK OR CREDIT CARD STATEMENT IS SUFFICIENT.</p> <p><input type="checkbox"/> YES, I WOULD LIKE A MONTHLY RECEIPT TO SUBMIT TO MY INSURANCE COMPANY FOR REIMBURSEMENT.</p> <p><input type="checkbox"/> YES, I WOULD LIKE A MONTHLY RECEIPT FOR REIMBURSEMENT FROM MY FSA/HSA.</p> <p><input type="checkbox"/> YES, I WOULD LIKE A MONTHLY RECEIPT FOR MY HOUSEHOLD RECORDS.</p> <p>IF YES, WHICH E-MAIL ADDRESS WOULD YOU LIKE YOUR MONTHLY RECEIPT SENT TO?</p> <p>_____</p>
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REFERRED BY	CAN I SEND THIS PERSON A THANK YOU NOTE?
CONTACT IN EMERGENCY	RELATIONSHIP
PHONE #	