Stacey S. Ward, MSW, LCSW, PLLC

CLIENT INFORMATION FORM-Adult

Demographic Information (Please print)

Name: ____ (Full Legal Name)

Sex: _____ DOB: ___/___/____ Age: ____ Race: ___________ Marital Status: __________

Sexual Orientation:_________________________________

Social Security Number: _____________________________

Home Address: ____

City: ________________________ State: __________ Zip Code: ___________

Home Phone: ______________________ Cell Phone: ____________________

Employer: ____

Work Phone: _________________________________

Is it okay to leave a message for you at any of these numbers? Yes No

If yes, what numbers are okay to leave messages? ________________________________

Please list others in the home with you:

	Name	Relation to you	Age
1)	____________________________	___________________________________	________
2)	____________________________	___________________________________	________
3)	____________________________	___________________________________	________
4)	____________________________	___________________________________	________

Emergency Contact

Name: ____

Address: ____

Numbers: ____

Insurance Information

Insurance Carrier: ___________________________

Name of Insured: ____________________________ SS #: ____________________________

DOB: ___/___/____ Relationship to You: __________________________

Policy Number: ___________________________ Group Number: _____________________

Numbers: ____

Primary Care Doctor

Name____

Address____

Number____

Treatment Information

Please describe briefly the problem(s) you are experiencing and what has led you to seek counseling (further details will be collected later):

____

____

____

____

____

____

Are you currently on medication? Yes No

If yes, please list medications____

If no, have you been on any psychotropic medications in the past? Yes No

If yes, please list medications____

Have you been in counseling before? Yes No

If yes, when and where____