CLIENT INFORMATION SHEET

Name: _____ Date of Birth: ___/___/_____.

Social Security Number: _____.
Address: _____.
_____.
City: _____.
State / Province / Region: _____.
Postal / Zip Code: _____.
Country / Region: _____.

Phone: _____.
Work Phone: _____.
Email: _____.

Profession: _____.
Employer or School: _____.

Emergency Contact Details

Name: _____.
Phone: _____.
Relationship: _____.

Insurance Details

Company: _____.
ID: _____.
Policy/Group No: _____.
Authorization No. (if required): _____.
Primary Subscriber Name: _____.
Insurance Phone: _____.

Medical

Primary Physician Name: _____.
Primary Physician Phone: _____.
Medical Concerns: _____.
_____.
_____.
_____.
Current Medications: _____.
_____.
_____.
_____.
Date of last checkup: ___/___/_____.

Emily Cohen LCSW 773-655-9404 emilycohenlcsw@gmail.com

What type of Counseling are you seeking?

☐ Individual ☐ Couple – Name of partner: ☐ Family

*If Couple's Counseling you are also agreeing to have your spouse/partner in some or all of the sessions.

Briefly describe the primary concern that brought you here:

_____.
_____.
_____.

What are you hoping to gain from counseling?

_____.
_____.

Previous Counseling or Therapy: (when and where)

_____.
_____.
_____.
_____.

Have you ever been hospitalized for a psychiatric concern? Yes/No
If yes, when and where? _____.
Reason for Hospitalization: _____.
Are you currently suicidal? Yes/No

Relationship Status: _____.

List all individuals living at home (Name, Relationship, Age and Occupation)

_____.
_____.
_____.
_____.

List all individuals that may be influencing your life (Name, Relationship)

_____.
_____.
_____.
_____.

Are you now or have you been concerned about (Please check):

- ☐ Physical Violence
- ☐ Sexual Abuse
- ☐ Rape
- ☐ Drug/Alcohol
- ☐ Terminal or Chronic Illness
- ☐ Learning Challenges
- ☐ Cultural or Identity Issues
- ☐ Finances
- ☐ Legal
- ☐ Suicide

☐ Other (Describe Below)

_____.
_____.
_____.
_____.
_____.
_____.

AGREEMENT OF PAYMENT

☐ Agree

☐ Do not Agree

*I understand that I will be responsible for payment of all services provided.
THERE IS A 24 HOUR LEEWAY FOR CANCELING APPOINTMENTS. IF YOU KNOW THAT YOU WILL NOT BE ABLE TO KEEP AN APPOINTMENET PLEASE CALL AT LEAST 24 HOURS IN ADVANCE. SERVICES WILL BE DISCONTINUED AFTER THREE CONSECUTIVE MISSED OR CANCELED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE. $100 SERVICE CHARGE WILL BE ASSESSED PER CANCELLED APPOINTMENT.

Signature: _____. Date: __/__/_____.

Print Name: _____.