Silver Lining Counseling Services LLC
Elizabeth Ross LMFT LPC
12295 Oracle Blvd. Ste 210
Colorado Springs, CO 80921
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Today's Date_______________________

Client Name____**Age**______**DOB**_____________________

Address:____**Zip**____________________

Home Phone______________________________**Work Phone**_________________________________

Cell Phone______________________**Email**____

Employer/School_____________________________________**SS#**___________________________

Business Address____**Zip**___________________

Father/Spouse_______________________________**Employer**________________________________

Business Address____**Zip**____________________

Mother/Spouse______________________________**Employer**_________________________________

Business Address____**Zip**___________________

Name of Insurance CO.__________________________**Insured**__________**Policy #**_______________

Address of Ins. CO ____**Phone**_________________

Secondary Ins. CO____**Policy #**_______________

Address of 2nd Ins. CO____**Phone**________________

In case of an emergency, list the name and phone number of a local relative or friend:______________
____

List all immediate family members (i.e. father, mother, spouse, children)

Name	DOB	Age	Sex	Relationship

Referral Source:______________________________________**Family Physician**__________________

Give a brief description of the reason(s) that you are here_____________________________________
____
____

Previous Therapy? Yes____**No**____**If so, with whom/reason/dates**______________________________
____

Signature of Client or Parent____