

Silver Lining Counseling Services LLC
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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 _____
