**CLIENT DATA SHEET**

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| DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Policy No. N/A | | Insurance Company: N/A | |
| Street Address: Apt. No. | | | |
| City, State, Zip: Parish/County: | | | |
| Home Phone: Cell Phone | | | |
| Social Security No.: | | Birth Date: | |
| Race: | Gender: | Religious Pref.: | Sexual Pref: |
| Primary Language (*it not English, please confirm that counselor is fluent in language of client or that a certified translator was present*) | | | |
| Transportation available for appointments? \_\_\_ Yes \_\_\_ No \_\_ N/A (telehealth or services at client home) | | | |
| Parent/Guardian Name (if applicable): | | | |
| Parent/Guardian Address (if different): | | | |
| Referral Source Name and Contact Info: | | | |
| Relationship of Referral Source: | | | |
| Emergency Contact 1:  Name: Phone: Relationship: | | | |
| Emergency Contact 2:  Name: Phone: Relationship: | | | |
| Primary Care Physician: Date of Last Visit:  Current Prescriptions and Medications: | | | |
| School Status/Grade: Educational Site (if any): | | | |
| Last Grade Completed: | | | |
| Occupation: Disability Status: | | | |
| Primary Diagnosis: Secondary: | | | |

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_