**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_