NEW LEAF COUNSELING

New Client Information

We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation, as well as potential solutions to meet your needs. *Please note - the information is confidential, for our use only, and will not be released to anyone without your written permission.

Personal Information

Client Name: ____

Date of Birth: _____/______/______ Age: ______

Street Address: ____

City/State/Zip:

____

I identify my gender as: _______________ (Male, Female, Etc.)

Home/Work Phone: _______________________________ Leave message? Y / N

Cell Phone: ______________________________________ Leave message? Y / N Text? Y /N

Email : ____

May we e-mail you? Yes No

Emergency Contact Name: ____

Emergency Contact Phone: ____

Student: _____ Y / N

School____

Employer: ____

Occupation: __________________________________ Length of Employment: ________

Insurance Information

Name of Insurance Company: ____

Insurance Co. Phone # (Mental Health): ____

Policy Owner’s Name: ____

Policy Owner’s Date of Birth: ______/_______/_______

Insurance ID #: _____________________________ Policy or Group#: _________________

Counseling Concerns

What are the issues for which you are currently seeking assistance? Please be as specific as possible.

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What do you consider to be your strengths?

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Referral Source

How did you learn about this office?

- Insurance Company: ___________________________

- Physician: ________________________________
- Internet Search or Website
- Advertising
- Friend Referral