

Feelings Forward Mental Health Counseling, PLLC

New client information

Date: _____

Client Name: _____ DOB: _____

Last four of your s/s#: _____

Address: _____

Telephone #: _____

Insurance Co: _____ Member ID: _____

Group #: _____

Subscriber's name: _____ DOB: _____

Last four of their s/s#: _____

Current physician's name/telephone number: _____

Current Diagnosis: _____

Past Diagnosis: _____

Current medications: _____

Reason for seeking treatment: _____

_____.

Previous treatment history: _____

_____.

Current home environment: _____

Supports: _____

_____.