Client Information

Client Name:	Sex: Male Female	Identifies As:
Address:	City:	Zip Code:
Phone:	Text: Yes No	County:
SSN:	**DOB:**	School:

Guardian Information

Guardian Name:	Relationship:	Email:
Address:	City:	Zip Code:
Phone:	Text: Yes No	County:
SS#	**DOB:**	

Emergency Contact

Check if same as guardian

Name:	Relationship:
Phone:	Text: Yes No

Financial

Medicaid-Carelogic (Attach copy of Insurance card)

Medicaid ID:	Medicaid MCP:
Other Info:	

Private Insurance-SimplePractice (Attach copy of insurance card)

Insurance Company:		Employer/Plan Name:
Subscriber Name:	Subscriber DOB:	Subscriber SSN:
Insured ID:	Group:	Co-pay/Deductible:

Benefits Contact:

Referral Information

Referring Individual/Agency:	Date of Referral:
Reason for referral: Mental Health Substance Use Behavior Concerns Emotional Regulation Court Ordered Traumatic Event Depression Anxiety Other:	
For Office Staff Only	
Assessment Date:	Provider:
Copies Obtained & Scanned: Insurance Card Individual/Guardian ID Social Security Card Intake PW	