



Carrollwood Counseling

Client Information Form

Live Life Well ©

Client: _____
First Name Middle Name Last Name

Marital Status: Married Divorced Separated Widowed Never Married

Address: _____ City and zip _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

By checking the box, I authorize a representative of Carrollwood Counseling to leave messages at these telephones: Home Work Cell Phone

Date of Birth: _____ Social Security Number: _____
(Month/Day/Year)

Employer: _____ Full Time Part Time Full Time Student

Primary Care Physician: _____
Name Address Telephone Number

Emergency Contact: _____
Name Relationship Telephone Number

Insurance: _____
Company Name ID #

Group # Account #

Insured Name: _____ Relationship to Client: _____

Insured Date of Birth: _____ Social Security Number: _____
(Month/Day/Year)

Insured Home Address: _____

Insured Employer: _____

Informed Consent

I consent to psychotherapeutic evaluation and treatment. Additionally, I understand that psychotherapy is a shared effort and I agree to do my part to effect successful treatment. If at any time I have questions about my treatment, I agree to discuss these with my therapist.

Client/Parent/Guardian _____ Date _____

Release of Information

I authorize the release of any information necessary to process my claim. _____
(Initials)

I authorize the release of any information to my Primary Care Physician. _____
(Initials)

Client/Parent/Guardian _____ Date _____

How did you hear about us? _____