# Robert B. Young LPC, LCAS

## Client Information

Name: _____

Street :_____

City:_____ State:____ Zip:_____

Phone: (H)_____ (W)_____

Social Security #:_____

Date of Birth: _____ Age _____

Education: _____

Occupation: _____

Employer:_____

Religion:_____

Medical Conditions:_____

Medications:_____

Allergies: _____

Physician: _____

Address:_____

Phone:_____ Fax: _____

## Spouse/Partner/Parent Information

Name: _____

Street :_____

City:_____ State:____ Zip:_____

Phone: (H)_____ (W)_____

Social Security #:_____

Date of Birth: _____ Age _____

Education: _____

Occupation: _____

Employer:_____

Religion:_____

Medical Conditions:_____

Medications:_____

Allergies: _____

Physician: _____

Address:_____

Phone:_____ Fax: _____

***INSURANCE COMPANY:***_____ ***POLICY # :***_____

***GROUP #:***_____ ***POLICYHOLDER'S NAME:***_____

***POLICYHOLDER'S BIRTHDATE:***_____ ***POLICYHOLDER'S SS#:***_____

***IF YOU HAVE BEEN REFERRED BY AN EMPLOYEE ASSISTANCE PROGRAM (EAP), PLEASE PROVIDE THE AUTHORIZATION NUMBER:***_____ ***AND THE NO. OF SESSIONS APPROVED:***_____***.***

Why are you here? _____

What do you want to be better when you leave? _____

Have you been in therapy before? _____ With whom?_____ When?_____

Children's Names Gender Age School Married? Live with you?

_____

_____

_____

Who referred you?_____ Will you give permission for me to thank them? _____

If I have to file your insurance, please sign below authorizing me to file your insurance and have the payments sent directly to me.

Name_____ Date _____