NorthSide Family Counseling Center
18756 Stone Oak Parkway, San Antonio, TX 78258

Client Information

_____ _____ _____

Last Name First Name ID No.

Phone Number _____ Birth Date: _____ Gender: _____ Marital Status: _____

Mailing Address: _____Zip Code _____

Place of Employment (or school if student): _____

Email _____Date of First Session: _____ SSN: _____

Insurance Name:_____ Insurance No:_____

Group No:_____ Insurance Subscriber's Name and DOB: _____

Reason for counseling: _____

_____

_____

General Information

Previous Marriages #? _____ Spouse's Name: _____

Children (if more, please write on the back):

Name: _____

Gender: _____ Age: _____

Name: _____

Gender: _____ Age: _____

Name: _____

Gender: _____ Age: _____

Church Affiliation: _____

Previous Counseling? YES NO If yes, date(s): _____

Name of Counselor: _____

If previous counselor provided a diagnosis, what was it? _____

Who referred you to us? _____

Medical Issues: _____ __

Medications: _____

Primary Care Provider/Psychiatrist Name/Phone Number: _____