Northside
FAMILY COUNSELING CENTER

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: _____