Initial Client Information — Adult

Renewed Hope Counseling Center

28900 Pontiac Trail, South Lyon MI 48178 phone 248-560-7507 Fax 248-667-9970

Client Name: (Mr./Mrs./Ms)_____ Date: _____

Address:_____
(Street) (City) (State) (Zip)

Date of birth: ____/ ___/ _____ Therapist: _____ Referred by: _____

Email: _____

Home Phone #: (_) _____ Work phone #: (__) _____ Cell Phone #: ( ) _____

Occupation:_____ Employer and address:_____

Marital status: _____ Spouse name:_____ SS #:_____

Spouse address (if different):_____ Date of birth: _ / ___

Home Phone #: (_) _____ Work phone #: (__) _____ Cell Phone #: ( ) _____

Occupation:_____ Employer and address:_____

Name of Child(ren):	Age:	Date of Birth:	Name of Child(ren):	Age:	Date of Birth:
_____	___	_____	_____	___	_____
_____	___	_____	_____	___	_____
_____	___	_____	_____	___	_____

Primary insurance company: _____ Policy holder's:_____

Contract #:_____Plan:_____ Group: _____ Effective Date:_____

Current mediation(s):_____ _____ Allergies: _____

Previous mental health providers (Name of doctor, facility, or therapist): _____

Emergency contact:_____ Relationship: _____

Address: _____ Phone number: ( ) _____