Top Level Counseling and Testing Center Initial Client Information Fact Sheet

Name: ____ Birth Date: _____ /_____/_____
Address: ____ Today's Date: _____ /_____/_____
____ Phone: (H) _________________
Employer: ____ Phone: (W) _________________
Address: ____ SSN: ____________________
Emergency Contact Name: _____________________________ Relationship: _______________
Phone Number: _______________________________________
Relationship Status: _______ Married _______ Yrs _______ Never married _______ Separated
_______ Committed Relationship _______ Divorced _______ Yrs _______ Widowed _______ Yrs
Children (Names and Ages): ____
____
Employer/School: ___________________________ Length of current employment: _____________
Address: ____
Occupation: ____
Responsible Parent/Guardian/Spouse Info:
Name: ____
Address/Phone: ____
Employer: ____
Who referred you to the clinic? ____
Have you been in treatment before? If so, where and when? ___________________________

Current reason for seeking treatment:
____ AODA
____ Academic/Career
____ Mood
____ Other: ____
____ Interpersonal
____ Court Ordered
____ Referred

Insurance/Billing Information

Primary Insurance Data:
Policy Holder: ______________________ Employer: ____________________________________
Insurance Company: ____
Address: ____
ID #: ______________________________ Group #: _______________________________________
Group Name: _______________________ Effective Date: __________________________________
Insurance Verification Phone: ____

Secondary Insurance Data:
Policy Holder: ______________________ Employer: ____________________________________
Insurance Company: ____
Address: ____
ID #: ______________________________ Group #: _______________________________________
Group Name: _______________________ Effective Date: __________________________________
Insurance Verification Phone: ____

Designated Family Physician: ____

Please print legal name clearly: ____
Signature: ____