Stacey Curl
INTEGRAL PSYCHOTHERAPIST • MA, LMHC

Client Information Form

Name: _____ Date: _____

Name on Insurance Card (if different than above): _____

Address: _____

Phone: _____ Email: _____ Age: _____

Date of Birth: _____ Gender Identity _____

Gender listed on insurance (if different than above): _____

Occupation or Grade (and school name): _____

Primary Insurance: _____ Subscriber: _____

ID#: _____Group#: _____ Phone: _____

Secondary Insurance:_____

Marital Status: ____Single ____ Married ____ Divorced/Separated ____Widowed ____ Living w/ someone

Children (Names/Ages): _____

_____

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

*Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Current Medications being taken:

1) _____ Dosage/Frequency _____ Purpose _____

2) _____ Dosage/Frequency _____ Purpose _____

3) _____ Dosage/Frequency _____ Purpose _____

4) _____ Dosage/Frequency _____ Purpose _____