JUSTINE STOHL, LICSW

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Client Information Sheet

NAME_____ DOB_____

ADDRESS_____

TOWN/STATE/ZIP_____

HOME PHONE_____WORK PHONE_____

CELL PHONE_____

EMAIL_____

EMPLOYER/SCHOOL_____FT/PT

FIRST LANGUAGE_____REFERRED BY_____

RELATIONSHIP TO SUBSCRIBER_____

NAME OF INSURANCE COMPANY_____

INSURANCE COMPANY ADDRESS

_____

ID NUMBER_____GROUP NUMBER_____

INS PHONE NUMBER_____ OTHER INFO_____

SECONDARY INSURANCE_____

ID NUMBER OF SECOND INSURANCE _____

****

Please complete if above name is different from subscriber

SUBSCRIBER NAME_____DOB_____

ADDRESS_____PHONE_____

EMPLOYER_____

****

PLEASE GIVE BRIEF REASON FOR SEEKING SERVICES_____

_____

_____

_____

_____

_____

_____

PAST HOSPITALIZATIONS FOR EMOTIONAL/MENTAL HEALTH? YES NO

IF YES, PLEASE BRIEFLY EXPLAIN

_____

_____

_____

_____

To be completed by clinician

DIAGNOSIS_____DATE OF FIRST VISIT_____

DATE OF ELIGIBILITY_____COPAY_____

DEDUCTIBLE_____YEARLY MAX_____PARTY? YES/NO

AUTHORIZATION REQUIRED? YES/NO IF YES, BY: PHONE/ONLINE/FORM

AUTH#_____#VISITS_____DATES_____