NEW CLIENT INFORMATION FORM

Quantum Counseling, LLC - Lillie Murray, LCSW

Doctor's Name	Referred By	Date of Initial Session

PATIENT INFORMATION - Please Complete All Applicable Information

Last Name	First Name	MI	Date of Birth

Gender	Marital Status	Spouse (Name)	Date of Marriage

Home Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone (Appt Reminder)	E-mail Address

Religious Preference (if applicable)	List Any Medications You Are Currently Taking (if applicable)

PARENT/GUARDIAN INFORMATION (if applicable)

Father's Last Name	First Name	Preferred Phone Number [home, work, cell] (please circle)	Marital Status

Mother's Last Name	First Name	Preferred Phone Number [home, work, cell] (please circle)	Marital Status

FAMILY INFORMATION (if applicable)

Children - Name(s) and Age(s)

Name	Age	Name	Age	Name	Age	Name	Age	Name	Age

EMPLOYMENT INFORMATION (if applicable)

Employer Name	Employer Phone

Employer Address	City	State	Zip Code

EMERGENCY CONTACT INFORMATION (Nearest Relative Not Living With You)

Contact's Last Name	First Name	Relationship to Patient	Phone Number

Home Address	City	State	Zip Code

PRIMARY INSURANCE INFORMATION (if applicable)

Insurance Company	Phone Number

Policy Holder's Last Name	First Name	MI	Date of Birth	Gender

Relationship to Patient	ID Number	Group Number	Plan Name

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company	Phone Number

Policy Holder's Last Name	First Name	MI	Date of Birth	Gender

Relationship to Patient	ID Number	Group Number	Plan Name

Signature of Responsible Party **Date**