Adonai Christian Counseling Services, PLLC.
New Client Information Form

Therapist: _____ Date: _____

Client Name: _____ ____Male ____Female

DOB: _____ Race: _____ County of Residence: _____

Home Address: _____

City: _____ Zip:_____

Home #: _____ Cell: _____ Work: _____

Email: _____

Parent/Guardian: _____ Telephone:

Email: _____

Private Insurance Company: _____ Policy #: _____

Policy Holder's Name: _____ Holder's DOB: _____

Place of Employment: _____ Group #: _____

Insurance Co. Phone: _____ SS#: _____

Insurance Co. Address: _____

Effective Dates: _____ Co-Pay Amount: _____Chg:_____

Misc. Information: _____Dis:_____

Psychiatrist: _____

Psychiatric Medications: _____, _____, _____

Date of Initial Assessment: _____ Duration of Session: _____

TX Plan Expiration Date: _____ Information Release Expiration Date: _____

Has the client been seen by any other therapist this year? Yes No

For Office Use Only:

Intake Date: _____
Axis 1:_____
Axis 2:_____
Axis 3:_____
Axis 4:_____
Axis 5: GAF Score: _____ Date of GAF: _____