

Today's Date: \_\_\_\_\_

Please Fill This Form Completely (front and back)

Client Information:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ May we contact you at work? \_\_Y \_\_N

Social Security Number: \_\_\_\_\_ Sec: \_\_Male \_\_Female

Marital Status: \_\_Married \_\_Divorced \_\_Separated \_\_Widow(er) \_\_Single

Spouse's Name: \_\_\_\_\_ Spouse's Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Children: (Names and ages) \_\_\_\_\_  
Parents Name \_\_\_\_\_ Custodial Parent: \_\_Y \_\_N  
(if client is under 18)

Insurance Information

Employer of Policy Holder/Insured Party: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Plan/Policy/group Number: \_\_\_\_\_ Member I.D. Number: \_\_\_\_\_

**Linda Kohn, LCSW Inc.**

295 West Crossville Road \* Suite 740 \* Roswell, GA 30075 \* (770) 993-7715/tel (678) 205-0434/fax

Insurance Company Name: \_\_\_\_\_

Insurance Company Claim Address: \_\_\_\_\_

Insurance Company Mental Health Division Telephone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_

Psychiatrist Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Current Medication: Please list all medications and dosages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prior Mental Health Treatment:  yes  no

List Providers: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Number of School Years Completed: \_\_\_\_\_

List all people living in your home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_