

Laurel E. Harris, MA, LPC  
825 E. Speer Blvd, Suite 215, Denver, CO 80218  
720-261-1567

CLIENT INFORMATION RECORD

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

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Emergency Contact (Name & Phone) \_\_\_\_\_

Is it O.K. to leave a message? \_\_\_\_\_ On which phone(s)? \_\_\_\_\_

Why have you come to counseling? \_\_\_\_\_

Have you been in counseling before? If so, when? \_\_\_\_\_

Do you have any physical complaints or medical issues? \_\_\_\_\_

Do you take any medications? If yes, what? \_\_\_\_\_

Primary Care Physician's Name and Phone \_\_\_\_\_

Name of Primary Insurance (if applicable) \_\_\_\_\_

Primary Insurance Phone Number \_\_\_\_\_

EAP Name (if applicable) \_\_\_\_\_

EAP Phone Number \_\_\_\_\_

EAP Authorization Number/# of Sessions Authorized \_\_\_\_\_