Aloha Counselors, LLC

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Client Information Record

Date:____________________________

Name of Client:____

DOB:___________________________(mm/dd/yyyy) Age: ____________ Pronoun preference: ______________

Name of parent/legal guardian if client is minor: ____

Parent/Guardian DOB if client is a minor: ___________________________________ (mm/dd/yyyy)

Mailing Address: ____

City: ____ State:____________________ Zip: ________________

Primary Phone: _(________)________________________ Cell Phone: _(__________)_________________________

Are you able and willing to accept cellphone text messages? ___________Yes ___________No

I can leave a message for you on _________Primary Phone ___________Cell Phone __________Other

Email: ____

Emergency Contact

Name: ____ Relationship: _________________________

Phone: _(________)__________________________ City and State: _______________________________________

Name: ____ Relationship: _________________________

Phone: _(________)__________________________ City and State: _______________________________________

Primary Physician Name: ____ Phone: (______)________________

Psychiatrist Name: ____ Phone: (_______)________________

Financial Information

Name of Person Responsible for Payment: ____

Address if Different From Above: ____

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Phone: ____

Insurance Company: ____

Subscriber/Member ID: ____

Group Number: ____

For Office Use Only

Insurance Card Image ○ Photo ID

○ Front ○ Back