



Rooted Mind

COUNSELING CENTER

1247 Milwaukee Ave. Suite# 208 Glenview, IL. 60025~224.257.4190

Client Information Form

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Client Information:

Date _____ Social Security # _____

First Name _____ Last Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Cell) _____ (Home) _____ (Work) _____

Birthdate _____ Age _____ Gender ___ F ___ M

Contact Methods for confirming or cancelling appointments:

Okay to leave a voicemail to cancel or confirm appointments? YES NO _____ initial here

Insurance Information:

Insurance company: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Relationship to Client: _____

Emergency Information: In case of emergency, please contact:

Name (1) _____ Relationship _____ Phone _____

Name (2) _____ Relationship _____ Phone _____

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____

Address _____ City _____ State _____ Zip _____

Are you currently taking any medications: ___yes ___no (include vitamins or herbal supplements)

Medication _____ Dosage _____

Medication _____ Dosage _____

Allergies _____

