Main Street Counseling Center - Sheri Golly, LCSW

Client Information Form

Client Information

Name: First _____ Middle _____ Last _____

Nickname: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number For Contact /Reminder Texts: _____

Email For Contact /Reminder Msgs: _____

Sex: ☐ *Male* ☐ *Female* Marital Status: ☐ *Married* ☐ *Single* ☐ *Other*

Employment Status: ☐ *Employed* ☐ *Unemployed* ☐ *Student*

Contact Information

Parent/ Guardian

Name: First _____ Middle _____ Last _____

Relationship: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number For Contact /Reminder Texts:_____

Email For Contact /Reminder Msgs: _____

Responsible Party For Billing ☐ *Same as above*

Name: First _____ Middle _____ Last _____

Relationship: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Email:_____

Insurance Information

Insurance Company: _____ CoPay: _____ Deductible: _____

ID Number: _____ Policy Group: _____

Employer/School: _____ Plan Name: _____

Policy Holder: _____ Date of Birth:_____

Presenting Concerns and Goals for Counseling

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