

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:
