FREMONT COUNSELING SERVICE

Client Information Form

Client's Last Name | **Client's First Name** | **Middle Initial**

Do you have a twin? ☐ Yes ☐ No

Maiden Name / Other Names or Aliases

Physical Address | **City / State / ZIP**

Mailing Address | **City / State / ZIP**

Email Address

Home Phone ☐ Mobile ☐ Cell **Can we leave a message?** ☐Voice ☐Text

Work Phone ☐ Mobile ☐ Cell **Can we leave a message?** ☐Voice ☐Text

Other Phone ☐ Mobile ☐ Cell **Can we leave a message?** ☐Voice ☐Text

Social Security Number | **Date of Birth** | **Mother's First Name**

Place of Birth: City / State / Country

Gender: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Never Married (1) ☐ Now Married (2) ☐ Divorced (4) ☐ Widowed (5) ☐ Minor Child (6)

Race: ☐ African American (B) ☐ Asian (A) ☐ Caucasian (C) ☐ Native American (N) ☐ Hispanic (H) ☐ Other (O) ☐ Native Hawaiian/Other Pacific Islander (P) ☐ More than One (M)

Hispanic Origin: ☐ Cuban (3) ☐ Other Hispanic (6) ☐ Mexican (5) ☐ Puerto Rican (4) ☐ Not Hispanic (2)

Employment Status: ☐ Unemployed (1) ☐ Less than 30 hrs/wk (2) ☐ More than 30 hrs/wk (3) ☐ Homemaker (4) ☐ Retired (5) ☐ Disabled: Unemployed (6) ☐ Child (0-15 yrs) (7) ☐ Student (16+ yrs) (8) ☐ Inmate (9) ☐ Other (O)

Residential Status: ☐ On Street or Homeless Shelter (1) ☐ Private Residence / Household (2) ☐ Group Home (3) ☐ Residential Treatment Center (4) ☐ Foster Home (5) ☐ Jail (6) ☐ Other Residential Setting (8)

Last Grade Completed: _____ ☐ No School (0) ☐ High School Diploma / GED (12) ☐ Bachelors (16) ☐ Masters (18) ☐ Doctoral (20)

Primary Language: ☐ English (E) ☐ Spanish (S) ☐ Sign Language (L) ☐ Other (O): _____

Veteran Status: ☐ Not a Veteran (2) ☐ Non-Combat Veteran (1) ☐ Combat Veteran (3)

Have you seen your primary care doctor in the last year? ☐ Yes ☐ No

Reason for appointment: _____

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EMERGENCY CONTACT INFORMATION:

Name **Address** **City / State / ZIP** **Phone Number**

Relationship: ☐ Spouse (E) ☐ Sibling (L) ☐ Father (B) ☐ Mother (P) ☐ Child (C) ☐ Domestic Partner (X)
☐ Foster Parent (F) ☐ Grandparent (G) ☐ Guardian (D) ☐ Legal Representative (T) ☐ Friend (R)

Who referred you to us?

☐ Self (1)	☐ Family / Friends (2)	☐ Law Enforcement (3)	☐ School (16)
☐ Attorney (28)	☐ Other MD (6)	☐ Other Private MH Provider (7)	☐ Wyoming State Hospital (9)
☐ DVR (19)	☐ Employer (17)	☐ Drug / Alcohol Treatment (11)	☐ Drug Court (23)
☐ DFS (18)	☐ CDS / Head Start (27)	☐ Juvenile Probation – DFS (26)	☐ Medical Hospital (21)
☐ Nursing Home (20)	☐ Shelter (13)	☐ Veterans Affairs (29)	☐ Adult Probation/Parole (25)
☐ Other (15)	☐ Clergy (8)	☐ Other MH Center (14)	☐ Court (4)
☐ Private Psychiatrist (5)	☐ CES / WLRC (22)	☐ Dept. of Corrections (30)	☐ Other Inpatient Treatment (10)

LEGAL STATUS ☐ Adult, no Guardian (4) ☐ Adult, has Guardian (3) ☐ Minor, has Guardian (2) ☐ Minor, Emancipated (1)

Guardian's Name **Address** **City / State / ZIP** **Phone Number**

Relationship: ☐ Spouse (E) ☐ Sibling (L) ☐ Father (B) ☐ Mother (P) ☐ Child (C) ☐ Domestic Partner (X)
☐ Foster Parent (F) ☐ Grandparent (G) ☐ Guardian (D) ☐ Legal Representative (T) ☐ Friend (R)

PERSON RESPONSIBLE FOR PAYMENT FOR SERVICES

Responsible Person's Name Social Security Number Date of Birth

Address City / State / ZIP Phone Number Relationship to Client

Employer Employer's Phone Number

PRIMARY INSURANCE INFORMATION – please present your insurance card to the front desk at check in. ☐ None

Name of Insured Client's Relationship to the Insured

Insured's Social Security Number Insured's Date of Birth

Insured's Employer Name Employer's Phone Number

Insurance Company Insurance Company Phone Number

Policy Number Group ID Number Copay Amount

Signature of Person Completing Form Date