DSA
COUNSELING WORKS

Client Information

Please complete this form. It provides essential details to be used in providing and evaluating the quality of client care provided to you by this office. It is appreciated that you do not leave any blanks; you may enter **NA** if the information requested is not applicable to you at this time.

Today's Date:_____

Subscriber Information:

Name:_____ DOB:_____ Age:_____

SS#:_____

Address:_____

_____

Phone Number(s):

(home)_____ (cell)_____

(work)_____

Insurance Company/ HMO:_____

Member ID#_____

Client Information: (if other than subscriber)

Name:_____ DOB:_____ Age:_____

SS#:_____

Address:_____

_____

Phone Number(s): (home)_____(cell)_____ (work)_____

Email Address:_____

Emergency Contact(s):

Name:_____ Relationship:_____

Phone Number(s):_____

Name:_____ Relationship:_____

Phone Number(s):_____