



COUNSELING SERVICES OF NEW ORLEANS, INC.
NEW CLIENT INFORMATION FORM

Asa R. Sphar III, Ph.D. and Associates - Individual/Marriage/Family Therapists

We appreciate this opportunity to serve your counseling needs. Please take a moment to provide us with the following information.

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Can we call you at work? Y / N

Place of Employment: _____ Occupation: _____ Education: _____

Age: _____ Birth Date: ___/___/___ Social Security #: _____ Marital Status: _____

Approximate **Gross** Family Income Per Year *or* That of the Sponsoring Third Party: _____

Briefly describe your reason(s) for seeking help: _____

When were you last examined by a physician? _____ Name of Physician: _____

Phone: _____ List any medications you are now taking: _____

Have you ever received psychiatric or psychological help or counseling of any kind before? Y / N

If yes, please explain: _____

List the members of your family and all others in your home:

<u>Name(s)</u>	<u>Age/Birth Date</u>	<u>Relationship</u>	<u>Occupation</u>	<u>Place of Employment</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who referred you to this office? _____

Name of person to contact in case of emergency: _____ Phone: _____

*If you believe insurance may cover a portion of your visits here, please complete the following information:			
Name of Insurance Company: _____	Phone: _____		
Group #: _____	Policy Holders S.S.#: _____	Policy #: _____	

Client(s) signature(s): _____ Date: ___/___/___

_____ Date: ___/___/___