**Please Type Directly on This Form**

|  |  |  |
| --- | --- | --- |
| [ ]  Individual [ ]  Child [ ]  Couple [ ]  Family [ ]  Consultation | Today’s Date |  |

**Client Information** (fill in 2nd name if couple)

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| City, State, Zip |  |
| Cell phone |  |
| Work/home phone |  |
| Email Address |  |
| Birth date |  |

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| City, State, Zip |  |
| Cell phone |  |
| Work/home phone |  |
| Email Address |  |
| Birth date |  |

**Financially Responsible Party** (if other than client)

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship to client |  |
| Address |  |
| City, State, Zip |  |
| Cell phone |  | Work/home phone |  |
| Email Address |  |

**Other Information**

|  |  |
| --- | --- |
| Household annual income *(to determine fee)*  | $ |

**Insurance Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Name |  |  Group Number |  |
| Insured Name |  |  Insured DOB |  |
| Relationship to Insured  |  |  ID Number |  |

**How were you referred to us?**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Therapist/Psychiatrist: |  | [ ]  Medical Professional: |  |
| [ ]  School/University: |  | [ ]  Other: |  |
| [ ]  Womencare Client | [ ]  Email | [ ]  Internet Search  | [ ]  Psychology Today | [ ]  Yelp/Google listing |

 I confirm that the above information is accurate.

|  |  |  |
| --- | --- | --- |
|  |  |  |

# Client signature Date

|  |  |  |
| --- | --- | --- |
|  |  |  |

*Client signature Date*

|  |
| --- |
| ***For Office Use Only*** |
| **Provider** | **First Session Date** | **Fee** |
|  **New Client Returning Client New Modality New Therapist** |



1740 Ridge Avenue, Suite 201, Evanston, IL 60201

|  |  |
| --- | --- |
| QB |  |
| Excel |  |

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