Office Use Only
Copay _____
Dx _____
Therapist _____ Date _____

PATIENT/CLIENT INFORMATION

Name _____ Age _____ Date of birth _____

Address _____
Number Street City ZIP

Phone _____ Cell _____ Status: Single [ ] Married [ ] Other_____

Occupation _____ Employer _____Work Phone _____

Prior counseling/therapy from _____ Year _____

Religious preference _____ Physician _____

Medications you are taking _____Soc Sec # _____

Medical insurance company _____ ID # _____

Name of Primary Insured _____ Their DOB _____

Person responsible for bill _____

In case of emergency call _____ Phone _____

Whom may we thank for referring you? _____

Children/Siblings

Name _____ Age _____ Grade _____ Name _____ Age _____ Grade ____

Name _____ Age _____ Grade _____ Name _____ Age _____ Grade ____

Name _____ Age _____ Grade _____ Name _____ Age _____ Grade ____

AUTHORIZATION FOR COUNSELING FOR SELF AND/OR A MINOR

I give permission to North Star Counseling to provide counseling/therapy services to myself/my

_____ _____ _____
Relationship Name(s) Signature Date