Initial Client Information – Adult

Crossroads Counseling, PLLC
3830 Packard Rd, Suite 160, Ann Arbor, MI 48108; Tel/Fax: 734.929.9703

Client Name: (Mr./Mrs./Ms)_____ Date: _____

Address: _____ _____
(Street) (City) (State) (Zip)

Date of birth: _____/_____/_____ Therapist: _____ Referred by: _____

Email: _____ SS #: _____ ____ _____

Home Phone #: (____)_____ Work phone #: (____)_____ Cell Phone #: (____)_____

Occupation: _____ Employer and address: _____ _____

Marital status: _____ Spouse name: _____ SS #: _____

Spouse address (if different): _____ Date of birth: ____/____/_ ___

Home Phone #: (____)_____ Work phone #: (____)_____ Cell Phone #: (____)_____

Occupation: _____ Employer and address: _____

Name of Child(ren):	Age:	Date of Birth:	Name of Child(ren):	Age:	Date of Birth:
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

Primary insurance company: _____ Policy holder's: _____ _____

Contract #: _____ Plan: _____ Group: _____ Effective Date: _____ ____

Current mediation(s): _____ Allergies: _____

Previous mental health providers (Name of doctor, facility, or therapist): _____

Emergency contact: _____ Relationship: _____

Address: _____ Phone number: (_____)_____

For Office Use Only

Therapist: _____ Fee: _____ Service(s): _____

Insurance: _____ Y _____ N Dx: _____