ETCH
EARLY TREATMENT & COGNITIVE HEALTH

CLIENT INFORMATION SHEET

Date of Initial Interview: _____ Therapist: _____

CLIENT INFORMATION:

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Living Arrangement: ☐ With family member ☐ With Significant Other ☐ With friends ☐ Alone

☐ Assisted Living Facility Name of Facility _____

Birthdate: _____ Social Security # _____ Gender: _____ Preferred Pronoun _____

First Name: _____ Last Name: _____ Middle Int._____

Address: _____ City: _____ State:_____

Zip: _____ Phone: _____ Cell #: _____ Email: _____

Emergency Contact: _____ Phone #_____
Name Relationship

Would an appointment reminder be helpful? ☐Yes, by: ☐Text ☐Phone ☐Email ☐No

HEALTH INSURANCE INFORMATION:

Health Insurance Carrier: _____ Employer: _____

ID#: _____ _____
Alpha

Group #: _____ Insurance Phone # _____

Insured Person (if other than client):

Last Name: _____ First Name: _____ Middle Int._____

Address: _____ Birthdate _____

City: _____ State: _____ Zip: _____ Phone #: _____

Secondary Insurance _____ ID#: _____ _____
Alpha

Group # _____ Insurance Phone #: _____

Office Use Only: ☐ Counseling ☐ Assessment Only

Initial Authorization # _____ Staff _____

Date _____ Time _____ Insurance Staff _____

Procedure Code _____ Diagnosis _____ Session Charge _____