BASICS
COUNSELING & TESTING
A DIVISION OF BASICS GROUP PRACTICE, LLC

CLIENT DEMOGRAPHICS

PERSONAL INFORMATION

CLIENT NAME _____ **PREFERRED NAME (IF APPLICABLE)** _____

PARENT/GUARDIAN NAME (IF APPLICABLE) _____

DATE OF BIRTH _____ **AGE:** _____ **RACE/ETHNICITY** _____

ADDRESS _____

GUARDIAN ADDRESS _____

PHONE NUMBER _____ **E-MAIL** _____

MOBILE NUMBER _____

INSURANCE CARRIER _____ **INSURANCE ID#:** _____

SUBSCRIBER NAME _____

REFERRAL SOURCE _____

CASE MANAGER NAME _____ **PHONE NUMBER** _____

PSYCHIATRIST NAME _____ **PHONE NUMBER** _____

PREVIOUS THERAPIST _____ **PHONE NUMBER** _____

PRIMARY CARE PHYSICIAN **PHONE NUMBER**

EMERGENCY CONTACT DETAILS

CONTACT NAME _____ **HOME NUMBER** _____

RELATIONSHIP _____ **MOBILE NUMBER** _____

OFFICE USE ONLY

DATE COMPLETED _____

PSYCHOLOGICAL TESTING? (Y/N) _____

COURT ORDER? (Y/N)
NOTE: COPY IN CHART _____

ASSIGNED CLINICIAN: _____

STAFF INITIALS _____

NOTES _____

THANK YOU