



Client Information Sheet: Please fill out, print and sign.

Personal Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell ph: _____

Email address: _____

Employer/School: _____ Occupation/Studying: _____

Relationship Status: _____ # of children and ages: _____

Referred by: _____

May I contact this person to thank them for the referral? Yes No

Primary Care Physician: _____

May I contact your PCP to let them know I am working with you? Yes No

Current medications and amounts: _____

Are you seeing any other health care professional such as a Naturopathic Physician, Acupuncturist or Massage Therapist? Please list: _____

Are you or anyone else concerned about your current use of medication, alcohol or drugs? Yes No

Insurance Information

Your relationship to insured: Self Spouse Child Other

Insured's Name (if not Self) _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer/School: _____

Insurance Plan Name and phone #: _____

Insured's I.D. Number: _____ Group# _____

Authorization and Release

I authorize payment of medical or government benefits directly to Jeffrey Morrison, MA, LMHC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Client Date

Print Name Date of Birth (if under 13)

Morrison Therapy and Training does NOT bill Medicare or secondary insurance.