AMY BECKMAN, LCSW

CLIENT INFORMATION AND REGISTRATION
(All information provided is confidential)

Name: _____ **DOB**:_____

Address: _____

Home Phone: _____ **Work Phone:** _____**Cell Phone**_____

E-mail Address:_____ **Occupation:** _____

Name of Employer: _____

In Case of Emergency Contact:
Name: _____ **Relationship:** _____

Home Phone: _____ **Work Phone:** _____

If you are under the age of 18 please complete:

Mother's Name: _____ **Father's Name:** _____

Work Phone (Mother):_____ **(Father):**_____

If separated/divorced list a second address and home phone:

Address: _____ **Home Phone:**_____

Insurance Information
Please complete or provide a copy of your insurance card.
Primary Insurance Company
Name:_____
Policy Number: _____ Name of Policy Holder:_____
DOB of Policy Holder_____

Do you have a secondary insurance plan? _____

Please summarize the reasons for seeking mental health services at this time.

_____

_____

_____

Identify any goals you may have for therapy at this time:

_____

_____

List any medications you are on presently:

_____

_____

Who referred you to this practice or from where did you hear about this practice?

_____