THE THERAPY CENTER FOR WELLNESS & RECOVERY LLP

INFORMATION FORM

Date: ________________

Name ____ Date of Birth _________________________

Address ____

City/State____ Zip Code____________________________

Phone number____ Alternate phone ______________________

Email address____

Insurance Company____

Policy Holder Name____ Date of Birth________________________

Employer____

School (if patient is a student) ____

SS number (for insurance purposes) ____

Referral Source____

Marital Status ____

Parent name if patient is a minor____

What brings you to therapy? ____