

Client Basic Information Sheet
Supportive Solutions, LLC

Client Name: _____

Age: _____ DOB: _____ Gender: _____

If Client a minor, Parent/Caregiver Name: _____

Address: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Insurance Carrier: _____

Group Number: _____ Enrollee ID # _____

Authorization Code: _____

What brings you to seek support?

Medical Information:

Current Medications:

Reason Prescribed:

Allergies: _____

Current Known Medical Problems (include physical and psychological information)

Additional Relevant Information:

