

- Superbill
- TH

Counseling Services Application					
Personal Information					
First name		Middle initial		Last name	
Today's date					
Mailing/Street address				City State Zip	
				Home phone:	
				Business phone:	
				Cell Phone:	
Birth date		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social security number (opt.)	
				Employer name:	
List present or previous health problems			List any medications you are currently taking		
Spouse Parent Information if under 18					
First name		Middle initial		Last name	
Marriage date					
Street address				City State Zip	
				Home phone	
				Business phone	
Birth date		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social security number (opt.)	
List present or previous health problems					
List any medications you are currently taking					
Children's Information					
Instructions: List all children					
Name		Birth date	Lives with you?	Name	
				Birth date	
				Lives with you?	
Other Information (PLEASE COMPLETE THIS SECTION)					
What do you hope to change or accomplish by seeking help at this time? (Use the back of the form if more room is needed.)					
List any agencies or other professionals who have provided you counseling services in the past. (Use the back of the form if more room is needed.)					
Signature			Signature		