



Aiding Therapy Services, PLLC

"Because we all need a little help sometimes."

Client Admission Form

Client Information

Client Name: _____

Address: _____

City: _____

State: _____

Zip: _____

DOB: _____

Relationship Status: _____

Gender Identity: _____

Income: _____

Occupation/Employer: _____

Primary phone number: _____

_ Text? Yes No

Voicemail? Yes No

Do we need to be discreet? Yes No

Alternate phone number: _____

Email: _____

Insurance Information

Insurance: _____

Group Number: _____

Member ID: _____

Primary Insured: _____

Relation to Client: _____

DOB of Primary Insured: _____

Gender Identity of Primary Insured: _____

Primary Insured Address (if different): _____

Primary Insured Occupation/Employer: _____

Other Household Members

<u>Name</u>	<u>DOB</u>	<u>Relationship</u>

11001 W 120th Ave Suite 400; Broomfield, CO 80021

(office): 720.372.3680

www.aidingtherapy.com

