Macomb Counseling Services, LLC
General Information

Name:_____
(Last) (First) (M.I.)

Parent/guardian:_____
(Last) (First) (M.I.)

Birth date: _____/_____/_____ Age: _____Gender: Male Female

Address:
_____
(Street and Number)

_____
(City) (State) (Zip Code)

Home Phone: _____ Cell/Other Phone: _____
May we leave a message? Yes No May we leave a voicemail or text? Yes No

Email: _____Referred by: _____

Emergency Contact Name: _____
Address: _____
Phone: _____
Relationship to Client: _____

Primary Care Physician Name: _____
Phone Number: _____Date of Last Exam: _____
Address: _____

Psychiatrist Name: _____
Phone Number: _____Date of Last Visit: _____
Address: _____

Auto Insurance Company: _____Claim Number:_____
Name of Adjuster: _____Phone Number:_____