FAMILY COUNSELING ASSOCIATES OF ANDOVER, LLC

New Client Registration Form

Date:_____ **Date of Birth:**_____

Client Name:_____

Client Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Telephone:_____**Cell:**_____

Email:_____ **Emergency Contact:**_____

Relationship: _____ **Emergency Contact's Phone:**_____

PARENT / GUARDIAN INFORMATION (FOR CLIENTS UNDER AGE 18)

Name:_____

□ check if address same as above

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Telephone:_____ **Cell:**_____

Email:_____

INSURANCE INFORMATION

Insurance Plan:_____

Identification #:_____

Mental Health Benefits Phone #:_____

Subscriber Name:_____ **Subscriber DOB:**_____

Relationship to Patient:_____

Please indicate the service(s) that you are seeking. Check all that apply:

❒ **Individual Counseling for Child/ Teen** ❒ **Individual Counseling for Adult**

❒ **Couple's Counseling** ❒ **Family Counseling** ❒ **Medication Management**

❒ **Psychological Testing** ❒ **Other: _____**

Please describe your counseling need. What type of counseling support are you looking for? :

_____

_____

_____

_____

_____

_____

Completed paperwork can be mailed to:

Family Counseling Associates of Andover
Attn: Intake Coordinator
12 Essex Street
Andover, MA 01810

Completed paperwork can be faxed to:
978-296-3460

*After we receive your information, we will contact you within one business day.