Cathy Fariss, MA, LPC
4131 Spicewood Springs Rd. Ste. K-6
Austin, Texas 78759
512-577-9932

Date ______________

Name ____

Address ____

City / State / Zip ____

Home Phone _________________________ Work Phone __________________________

Occupation __________________________ Employer ____________________________

Sex ______ Date of Birth ___________ Age _____ Education________________

Ethnic Background __________________ Name of physician _____________________

In case of emergency contact: ____

____

Name(s) of previous therapist(s) and dates seen: __________________________________

____

Describe any health concerns: ____

____

List drugs / medications you presently use: ______________________________________

____

Referred by _________________________ Phone ______________________________

Please describe briefly the concern(s) which bring you here: _________________________

____

____

Insurance Information

Name of Primary Insurance: ____

Subscriber's Name: ____

Client's Relationship to Subscriber: ___Self ___Spouse ___Child ____Other

Client's Birthdate: __________________ Policy /Group # :_______________________

ID#:____

Customer Service #:____

Name of Secondary Insurance: ____

Subscriber's Name: ____

Client's Relationship to Subscriber: ___Self ___Spouse ___Child ____Other

Client's Birthdate: __________________ Policy /Group # :_______________________

ID#:____

Customer Service #:____