Adolescent and Family Growth Center, Inc
Outpatient Services
8000 Forbes Place
Springfield, VA 22151
(703) 425-9200

CLIENT FACESHEET

Initial Appointment Date: ______________________

Client Information:
Please fill in the following information

Name: ____

Date of Birth: _________________ Social Security Number: ____________________

Birthplace: ____________________________________Sex: ___ Marital Status: ______

Address: _______________________________ City: _______________ Zip: ________

Employer or School: ____

Home Phone: _____________________ Work Phone: ____________________________

Cell Phone: ______________________ E-Mail: ______________________________

Current Medication (Include Dosage & Frequency):
____
____
____

Physician Name: _______________________ Phone: _______________________

Physician Address:
____

Do you have any allergies? YES NO
If yes, explain: ____

Do you have any medical problems: YES NO
If yes, explain: ____

Do you have any communication problems? YES NO
If yes, explain: ____

Do you have a history of substance abuse? YES NO
If yes, explain: ____

Do you have an advance directive? YES NO If so, please provide copy.

Emergency Contact Information:

Name: ____________________________ Relationship to Client: __________________

Address: _____________________________ City: ________________ Zip: _________

Home Phone: ___________________________ Work Phone: ______________________
Cell Phone: ______________________________

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Payment Information

To be filled out prior to first session

Full Name of Insured: _________________________ DOB: __________ Sex: _______

SSN of Insured: ______________________________

Address of Insured: ____
City: ________________________ State: ______________________ Zip: ____________

Client's Relationship to Insured Person: Myself Spouse Dependent Other: _______

Insured Party's Employer: ____

Employer Address: ____

Employer Phone #: ____

- ☐ The fee for your session is ______________________ per session.
- ☐ Our contact with your insurance company indicates your co-pay amount per session is __________.
- ☐ Our contact with your insurance company indicates you have _______________ approved sessions.

Copy of Insurance card and photo ID of the insurance must be received and attached to this document prior to the first session