

Kate Donnally, LICSW

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Client Demographic Information

Welcome to my practice. I would like to make the most of each session that we have together. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Parent / Guardian Information:

Complete name of parent or guardian: _____

Address: _____

City: _____ Prov/State: _____ Zip/Postal Code: _____

Home phone: _____ Daytime number: _____

Age: _____ Birth date: _____ Birthplace: _____

Education (grade completed, any postsecondary): _____

Current Occupation: _____

Relationship status (circle one): Single Partnered Engaged Married Separated Divorced
Widowed

Spouse/partner's 1st name: _____ Age: ___ Yrs in relationship: _____

Children (gender, age): _____

Identified Client Information (The person who will be seen primarily):

Complete name of young person: _____

Age: _____ Birth date: _____ Birthplace: _____

Education (current grade and school name): _____

Person to alert in the event of medical emergency: _____

Relationship to the young person: _____ Phone: _____

Primary Care Provider (Doctor, NP, PA, Naturopath): _____

Phone: _____

Additional treatments (i.e. Acupuncture, Occupational Therapy): _____

Please list the practitioner and contact information: _____

How did you come to find my practice (i.e. PCP, internet)? _____

Primary Insurance Information

Insurance Company and Type (HMO, PPO, etc.) _____

Member ID # _____ Group/Plan# _____

Insurance Phone # (for benefit or claims information from your card) _____

Claims address (from your card) _____

Are you the policy holder? Yes___ No___ If no, complete the following about the policy holder:

Policy holder's name _____

Address & Phone # (only if different than yours) _____

Birth Date _____

Employer _____

Your relationship to policy holder _____

Secondary Insurance Information

Insurance Company and Type (HMO, PPO, etc.) _____

Member ID # _____ Group/Plan# _____

Insurance Phone # (for benefit or claims information from your card) _____

Claims address (from your card) _____

Are you the policy holder? Yes___ No___ If no, complete the following about the policy holder:

Policy holder's name _____

Address & Phone # (only if different than yours) _____

Birth Date _____

Employer _____

Your relationship to policy holder _____