RAYMOND H. TESKE, LCSW
TESKE & ASSOCIATES
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303-756-6110
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CLIENT INFORMATION FORM

Patient Name_____Date_____

Address_____City_____State_____Zip Code_____

DOB _____Gender M F Responsible Person_____

Phone (H)_____Phone (W)_____

Marital Status_____Name of Spouse/Significant Other_____

Insurance_____Type of Plan_____

SS#/ID #_____Group#_____Ins. Phone # _____

EAP coverage?____Name & Phone of EAP_____

Is Precertification Required?_____Precertification Tele. #_____

Employer_____Address_____

Position_____Years at Employer_____

Medical Problems/Conditions

Medications/Dosage(s)_____

Primary Care Physician_____Phone_____

Previous Counseling & Reason for Treatment_____

_____

_____

(continue on back if appropriate)