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Client Information

Referred by: _____ Today's Date: _____

Client Name: _____ Date and place of birth: _____

Current Age: _____ Email(s): _____

Mailing Address:_____ Zip: _____
Physical/Home Address (if different from above):_____

Phone: _____ (home); _____ (cell); _____ (work)
Circle numbers where it is OK to leave a message

Insurance Carrier: _____ Emergency Contact: _____
(name and phone number)

Subscriber/Member/Medical Record Number: _____

Subscriber Name if different from client: _____ Subscriber Date of Birth:_____

Other insurance? _____ If yes, what is primary plan? _____

Marital Status: _____

Mother's name (if client is a child) _____ Date and place of birth _____

Address and phone (if different from above named client):
_____

Mother's current employer/working hours: _____

Father's name (if client is a child) _____ Date and place of birth _____

Address and phone (if different from above named client):
_____

Father's current employer/working hours: _____

(over please)

Names of other children/family members, DOB and ages: _____
_____

Children's Schools: _____

Current situation and concerns for which you are seeking therapy:

How long has it been going on?

Previous therapists' names/numbers: _____
(They will not be contacted without your consent.)

Primary Care Physician name/number:_____
(They will not be contacted without your consent.)

Current medications, dosage and reasons for use: _____
_____
_____

Other physical, emotional, mental conditions of which I should be aware?
_____

Thank You!

I look forward to our time together…….