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CLIENT INFORMATION

Date: _____ Referred by: _____

Name: _____

Preferred name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Okay to leave a message? YES NO

Work Phone: _____ Okay to leave a message? YES NO

Cell Phone: _____ Okay to leave a message? YES NO

Email: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Ethnicity: _____ Gender: _____

Sexual Orientation/Identity: _____

Relationship Status: _____ Partner's Name: _____

Responsible Party (if client is a minor): _____

Employer: _____

Profession: _____
OR
School: _____

Grade/Year: _____ Area of Study: _____

Name of Emergency Contact: _____

Relationship of Emergency Contact to you: _____

Emergency Contact Phone Numbers: _____

Insurance Company Name: _____ Employer: _____

Subscriber Name: _____ ID#: _____ Group #: _____

What brings you to therapy/counseling at this time? _____

_____

_____

_____

_____

_____

Previous therapy/counseling? YES NO

If so, when? _____ Where? _____

With whom? _____

How did you learn of my practice? _____

Are you taking psychotropic medication? YES NO

Name(s) of medication(s): _____

_____

Dose and frequency of each: _____

_____

Treating Physician or Nurse Practitioner: _____

Phone Number: _____

Other information you think I should know in order to better help you? _____

_____

_____

_____