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CLIENT INFORMATION FORM

DATE _____

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____

CITY/ZIP _____

HOME PHONE # _____

BUSINESS # _____ CELL# _____

At which of these numbers may I leave messages? _____

May I contact you by mail? YES _____ NO _____

DRIVER'S LIC _____ OCCUPATION _____

APPROXIMATE YEARLY INCOME _____

EDUCATION (LIST DEGREES) _____

MARITAL STATUS _____ CHILDREN/ AGES _____

WITH WHOM DO YOU LIVE? SPOUSE _____ PARENTS _____ OTHER _____

LIST 2 PERSONS TO BE CONTACTED IN CASE OF AN EMERGENCY

NAME/RELATIONSHIP _____ PHONE _____

NAME/RELATIONSHIP _____ PHONE _____

PLEASE LIST ANY CURRENT HEALTH PROBLEMS

_____

PLEASE LIST ANY MEDICATIONS AND DOSAGES

_____

PHYSICIAN'S NAME/ PHONE # _____

HAVE YOU BEEN HOSPITALIZED FOR PSYCHOLOGICAL REASONS OR DRUG DEPENDENCY?

YES _____ NO_____ If yes, please describe _____

NAME/ NUMBER OF PSYCHIATRIST (If Applicable) _____

ISSUES THAT BRING YOU TO THERAPY

_____

PRIOR THERAPIST (S) AND LENGTH OF THERAPY

_____

REFERRED BY _____ PERMISSION TO ACKNOWLEDGE? _____