Client Information

Name ____Date _________________

Phone #s (Is it OK to contact you and leave a message?): Home: ___________________________Yes / No
Work: ________________________Yes / No Cell: ____________________________Yes / No

Address (street, city, zip): ____

May I mail to you at this address? Yes / No Email: _______________________May I Email you? Yes / No

Gender: Male / Female Date of Birth: ___/___/___ Social security number:______________________

Occupation: __________________________ Employer: ____

How long have you worked there? ______________ How long in this occupation? ____________________

Education (highest level attained) and or career training: ____

Marital status: single / married / separated / divorced List names and ages of others living at home:
____
____

Primary Physician: ____ Phone: ___________________________

List diagnosed physical and mental conditions: ____
____

List any other significant health problems: ____
____

List any medications you are taking (name/dose/ frequency): ______________________________________
____
____

Previous therapy? Yes / No If Yes, when and with whom____
____

Give brief description of your therapy experience: ____
____

Primary reason you are currently seeking services____
____

How were you referred to this office? ____

Who may I thank for referring you? ____

Emergency contact name and #:____