CLIENT INFORMATION SHEET

Date: ______________________ Single/Married: _______________

Name: ____

Address: ____

Home Phone: ____________________ Cell Phone: ___________________

E-mail: ____

Date of Birth: __________________ SSN:___________________________

Occupation: ____

Employer: ____

Name of Spouse or Significant Other: _________________________________

Minor Children? If yes, names and ages: ______________________________

____

Referral Source: ____

Are you currently working with another therapist? (If so, who?)

____

Have you had any therapy experiences before? (If so, when?)

____

Are you on any medications at this time? If so, list them:

____

Contact in case of emergency: ____

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DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM I MAY DISCUSS YOUR MEDICAL CONDITION? Yes/No
IF YES, WHOM? ____

____

NOTE: you may revoke or modify an authorization with regard to any family member or other individual but such revocation or modification must be in writing.

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What brings you here today? ____

To bill insurance, I will need a copy of your insurance card. If you are not the actual policyholder, I will also need:

- **Policy holder's name, address, telephone no.**
- **Policy holder's SSN and date of birth**

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