

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: _____

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: _____

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM
I MAY DISCUSS YOUR MEDICAL CONDITION? 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.

What brings you here today?

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

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