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CLIENT INFORMATION SHEET

Client Information

Name: _____ Date: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Best Place to Leave a Message: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Social Security Number: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to You: _____

Health Information

Name of Physician: _____ Phone: _____

Date of Last Physical Exam: _____

Medications: _____

Significant Medical History (chronic conditions, major illnesses, surgery, etc.): _____

_____

_____

Previous Psychiatric History

Name of Provider: _____ Dates in Treatment: _____

Address: _____

Reason and Type of Treatment: _____

Name of Provider: _____ Dates in Treatment: _____

Address: _____

Reason and Type of Treatment: _____

History of Hospitalizations: Yes No

If yes, list dates, locations and reasons: _____

_____

Person Responsible for Payment

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____

Insured's Social Security: _____

Current Concerns:

Briefly describe the reason for seeking help at this time:

_____

_____

_____

Signature: _____ Date: _____