

Open Date: _____

Close Date: _____



CLIENT INFORMATION:

Name: _____

Phone: (Cell or Wk) _____ Can we leave messages? ___ Yes ___ No

Phone: (Hm) _____ Can we leave messages? ___ Yes ___ No

Address: _____ City: _____

State: _____ Zip: _____

May I have permission to mail to this address? ___ Yes ___ No

Email: _____ Can we correspond by e-mail? ___ Yes ___ No

Gender: Male ___ Female ___ Date of Birth: _____

Others living at home: _____

Employer: _____

Education: (List highest level of education attained) _____

Primary Care Physician: _____ Phone: _____

List any significant health problems: _____

List any medications you are taking and the dosage. Please list on back of page.

In the event of an emergency, whom should we contact? _____ Phone: _____

What is their relationship to you? _____

Have you in the past or are you presently using alcohol, drugs, or tobacco? ___ Yes ___ No

How often do you utilize alcohol, drugs, or tobacco per week? _____

Have you seen this type of therapist before? ___ Yes ___ No

If yes, when and with whom? _____

How were you referred to our office? _____

Who may we thank for referring you? _____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: _____

Phone (if different from above): _____

Address (if different from above): _____

Insurance Carrier or EAP (if applicable): _____

Social Security Number of Insured: _____

Group Number: _____ Insurance Phone Number: _____