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Client Information Form

Today's date: _____

A. Identification

Client's name: _____ Age: _____

Client's date of birth: _____ Client's Social Sec. # _____

Home address: _____

City: _____ State: _____ Zip: _____ Email address: _____

Home/evening phone: _____ Work phone: _____ Cell phone: _____

Which number is best for our office to contact you? *Check all that apply* ___ home ___ work ___ cell

Calls will be discreet, but please indicate any restrictions: _____

B. If patient is a child, please complete this section.

Mother's name: _____ Mother's employer: _____

Father's name: _____ Father's employer: _____

Which parent(s) should our office contact regarding the child's treatment? _____

C. Referral: How did you get my name?

___ Phone book ___ Insurance ___ Friend/relative ___ Medical provider ___ Psychotherapist

___ Psychiatrist ___ Other (specify) _____

If someone referred you to my practice:

What is this person's name? _____ What is his/her phone number? _____

May I have your permission to thank this person for the referral? ___ yes ___ no

How did this person explain how I might be of help to you? _____

D. Your medical care: from whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ___yes ___no
