CLIENT INFORMATION FORM

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: (Last) (First) (Middle Initial)____

Birth Date: ______ /______ /______ Age: _____________ Phone: ___________________

Home Address:____

Current Employer/Educational Institution:____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ____

Insurance. Are you the primary subscriber on your insurance? □ Yes □ No □ N/A

If No, please list the Name, Birth Date, and Address of the primary subscriber below:

Name: (Last) (First) (Middle Initial)____

Birth Date: ______ /______ /______

Home Address:____

Emergency information. If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I contact?

Name:______________________ Phone:_____________ Relationship:_______________

Coordination of care. If you enter treatment with me, may I tell your doctor so that he or she can be fully informed and we can coordinate your treatment?

Primary Care Provider: □ Yes □ No If No please initial here:_______

Psychiatrist: □ Yes □ No □ N/A If No please initial here:_______

If Yes I will provide you with a separate release of confidential information form for each physician indicated above.

____

Signature Date