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, I can contact your doctor so that he or she can be fully informed and we can coordinate your treatment. Would you like me to contact your doctor?

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