Confidential Client Information

Date: ________________________________

Name: ____

If Client is a Minor, Caregivers' Names: ____

Home Address: ____
____

Home Phone: ____

Employer: ____
Occupation: ____
Work Address: ____
____

Work Phone: ____

Cell Phone: ____
E-Mail Address: ____
Fax Number: ____

Date of Birth: _____________________________________
Social Security Number:_____________________________

Marital Status:_____________________________________
Number of Previous Marriages: _______________________

Current Psychotherapist (if applicable): ____
Current Psychiatrist (if applicable): ____
Current Physician:____
Have you had a physical exam within the last year? _______________________________

Medications/Drugs Currently Used: ____
____
____

Do you wish to utilize health insurance to pay for services? _________________________

How would you prefer that I contact you? (Please check at least one option from each column):

___ Home Phone ___ Home Address

___ Work Phone ___ Work Address

___ Cell Phone ___ E-Mail

___ Fax

Please provide the name and phone number(s) of whom I may contact in case of emergency:

Name: ____

Phone Number(s): ____

____

Referred by:

Website ____

-or-

Name ____

Title/Position ____

Company ____

Address ____

____

Phone ____

Fax ____

E-Mail ____

Do I have your permission to inform this person that you have contacted me? ____

Please briefly describe your reason(s) for seeking therapy at this time: ______________

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