CLIENT INFORMATION SHEET

Date: _____ Single/Married: _____
Name: _____
Address:_____
_____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Date of Birth: _____ SSN:_____
Occupation: _____
Employer: _____
Work Telephone No.: _____
Name of Spouse or Significant Other: _____
Children? If yes, names and ages: _____
_____
Referral Source: _____
Insurance Info (Type, Member ID, Primary Card Holder):
_____
Have you had any therapy experiences before? (If so, when?)
_____
Are you on any medications at this time? If so, list them:
_____
_____
Contact in case of emergency: _____
_____
May the therapist contact you via phone, text, or email? (If so, what is your preference?) _____
What brings you here today? _____
_____
_____
_____