

CLIENT INFORMATION

Name: _____

Date of Birth: ____/____/____ Age: _____ SS#: _____ - _____ - _____

Spouse's Name: _____ Spouse's Date of Birth: ____/____/____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Other: _____

Email Address: _____

Gender: __ _____ Male _____ Female Ethnicity: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Employment Status: __ Full-Time __ Part-Time __ Student __ Unemployed __ Disabled __ Other

Employer: _____ Position/Occupation: _____

Primary Care Physician/Psychiatrist: _____ Phone #: _____

Do You Want Information Released To Your Doctor? _____ Yes _____ No

If Yes, Please Provide Address: _____

Emergency Contact Name & # _____ Relationship to Client: _____

Who referred you: _____

Home Phone: _____ May we leave a message? Yes No

Cell: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Client (Or Guardian) Signature: _____ Date: _____