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CLIENT INFORMATION

Last Name ______________________________ First Name ______________________ Middle Initial ____

What name would you like me to use? _________________

Home Address ________________________ City __________________State _____ Zip Code ________

Home Phone (______) ______-__________ Cell Phone (______) ______-__________

Email _______________________________

Employer ______________________________________ Occupation ___________________________

Work Address ___________________________ City _________________________ Zip Code ________

Date of Birth ___/___/___ Age ___ Gender Identity:________ Social Security Number _____-____-_____

Relationship Status:

Single ___ Married ___ In a Committed Relationship ___ Widowed ___ Divorced ___ Separated ___

RESPONSIBLE PARTY FOR PAYING THE FEE Same as above ______

If responsible party is not the same as above, please complete this section for the responsible party.

Last Name ______________________________ First Name ______________________ Middle Initial ____

Home Address ___________________________ City _________________________ Zip Code ________

Home Phone (______) ______-__________ Work Phone (______) ______-_________ Ext. ______

Relationship to the client: Partner Parent Other ___________ Social Security Number _____-____-_____

INSURANCE INFORMATION (if you plan on using it)

Insurance Company Name ______________________________________ Phone (_______) _______-___________

Address to Submit Claims ______________________________________ City______________ ___ St_____ Zip_______

Contact Person at Insurance Company _____________________________ Group No ________________________

Subscriber's Last Name ___________________________________ First _____________________________ MI _______

Subscriber's Address ____ City______________ ___ St_____ Zip_______

Subscriber's Employer ______________________________ Work Phone (_______) _______-__________ Ext. _______

Subscriber's ID _________________________ Subscriber's Social Security Number_____________________________

Subscriber's Date of Birth ________________________________Client's Relationship to Subscriber __________

REFERRED BY

Last Name ____________________________________ First Name ___________________________

Phone (_______) _______-____________ May I thank the referral? Yes No

FAMILY INFORMATION

Please Fill in the Blanks for all Persons Living with You.

And Children NOT Living with In this Column

NAME	AGE	RELATIONSHIP	Name	Age

MEDICAL INFORMATION

Please Described Past and Present Health Issues____

____

____

When Was Your Last Medical Checkup? _______________________________

Who is Your Primary Care Doctor? _______________________________________

Please Describe Your Caffeine Intake ______________________________

If You Smoke, How Much? ____

Have you ever been to see a therapist before now? If so, when and with whom? ________________________

____

Have you ever been hospitalized for mental health reasons? ____

Have you ever participated in a drug or alcohol rehabilitation program? ________________________________

Are you currently involved in any legal proceedings (e.g., Workers Comp, Disability, Custody, etc)? ________

____

If You Are Taking Any Medications, Herbs Or Supplements, Please Fill Out The Following Chart:

MEDICATIONS HERBS/SUPPLEMENTS	DOSAGE (Amt. & Time)	STARTED WHEN?	TAKING FOR WHAT PURPOSE	PRESCRIBING DOCTOR

IN CASE OF AN EMERGENCY, WHO SHOULD BE CONTACTED?

Name ___________________________________ Relationship ______________________________________

Home Phone (______) ______-___________ Work Phone (______) ______-__________ Ext. _______

ANY ADDITIONAL INFORMATION YOU FEEL IS IMPORTANT FOR ME TO KNOW _______________

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