Client Information

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Telephone: Home_____ Cell_____ Work_____

Date of Birth_____ Social Security Number_____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

Are you currently employed? Yes_____ No_____

If yes, name of employer_____

Position held_____

Highest level of education_____

If married, spouse's name_____ Spouses' age____

If spouse employed, name of employer_____

Position held_____

If you have children (including step-children), please list their names and ages:

_____

_____

_____

Father_____ Living? No___ Yes___ Age_____

Mother_____ Living? No___ Yes___ Age_____

Step-parents_____ Living? No___ Yes___ Age_____

_____ Living? No___ Yes___ Age_____

Please list the names and ages of siblings:

_____

_____

_____

Current medical conditions_____

_____

Name of primary physician_____

Current medications_____

_____

How were you referred to this office?_____

Insurance information: Insurance company_____

Contract number_____

Group number_____

Name of policy holder_____

If not yourself, policy holder's date of birth_____

Policy holder's social security #_____

Other policies that cover mental health treatment? Yes____ No____

If yes, please describe_____