Client Information

This information will be kept confidential as part of your client file. Please answer as completely and accurately as possible in the interest of saving time and assisting your therapist to effectively serve you.

Date: _____

Primary Client's Name: _____ Date of Birth: _____
Age: _____ M ____ F____

Parent(s):_____

Age(s):_____

Marital status (please circle): Single | Married | Widowed | Separated | Divorced | Cohabitating

Spouse/partner's name:_____ Age: _____

Other family members attending sessions:

_____

Others living in the home (please give names and ages): _____

_____

Address: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Email address: _____

How would you prefer us to contact you? _____

Name and phone number of person to notify in case of an emergency:

_____

Relationship of emergency contact person: _____

Medications: Please provide name, dosage, date meds began and what prescribed for?

_____

_____

Please describe any medical conditions: _____

_____

_____

_____

Name/phone number of your primary care physician:

_____