Client Information Form

Today's Date____________

Client's Name____
(first) (middle initial) (last)

◇ Minor ◇ Married ◇ Unmarried ◇ Separated ◇ Divorced ◇ Widowed

Address____

Birth Date______________ Age__________ Ethnicity_________________________

Email_________________________________Home Phone_____________________

Social Security #________________________ Cell Phone________________________

Occupation _________________________ Work Phone ______________________

Employer___________________________

Employer Address____

Spouse or Parent's Name____
(first) (middle initial) (last)

Address____

Birth Date______________ Age__________ Home Phone_____________________

Occupation __________________________ Cell Phone________________________

Employer ___________________________ Work Phone ______________________

Employer Address____

Friend or Relative to contact in case of an emergency:

Name____ Phone_______________
(first) (last) (relationship)

Address____

Referred By________________________________ May we thank them? Yes No

Physician Name____________________________ Phone______________________

Previous Psychotherapy? No Yes If yes, Therapist Name____________________

Request Insurance Forms (for you to submit to your insurance company): No Yes

I understand that payment will be made at the time of each session and I hereby assume full responsibility for the expenses incurred in the care of the client listed above. I understand that I am responsible for all charges, regardless of insurance coverage and am responsible for any charges incurred in collection efforts. **I agree to pay $30 for any returned checks. I understand that all cancellations must be made 24 hours in advance otherwise a full charge will be made.**

Signature:________________________________Date:____________________