Ruchi Bhargava, Ph.D.
Licensed Psychologist

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Client Background Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email Address: _____

Preferred Method(s) of Communication:

☐ Phone	May I leave a message?	☐ Yes ☐ No
☐ Text	May I leave a message?	☐ Yes ☐ No
☐ Email	May I email you?	☐ Yes ☐ No

Date of Birth: _____ Age: _____

Relationship Status: ☐ Single ☐ Significant Relationship ☐ Married/Partnered
☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Gender/Pronoun Choice: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

Religious Affiliation (if any): _____Highest Level of Education Completed: _____

Employed Outside the Home: ☐ Yes ☐ No ☐ Part-time Occupation/Title:_____

Emergency Contact Information:
Name: _____Phone: _____Relationship: _____

Referral Information:
How did you hear about my practice? _____

Do you give permission to thank this referral source ☐ Yes ☐ No

Coordination of Care
Please list any providers with whom you are currently in care. Should coordination of care be needed, I will ask you to complete an Authorization to Release Information Form. Please include their name, address, and phone number.

Primary Care Physician: _____

Psychiatrist/ Other _____