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Client Information Form

Date: _____

A. Identification

Your name: _____Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Ethnicity:_____

Home street address: _____ Apt.:_____

City: _____ State: _____Zip: _____

Marrital Status (please check): _____Single _____ Divorced _____ Separated _____Married

Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions:_____

CELL:_____

Any restrictions on sending mail to your home address? _____
_____

B. Referred By: Name: _____

C. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____

Medical Problems and medications: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? _ Yes _ No

D. Your current employer
Employer: _____ Address: _____
_____
Work phone: _____Calls will be discreet, but please indicate any restrictions: _____

_____

E. Your education and training

Dates From	To	Schools	Degree	Adjustment to school	Did you graduate?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

F. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____	_____
Uncles/aunts	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

G. Spouse/Partner history

	Name	Age When Married	Age When Divorced
First	_____	_____	_____
Second	_____	_____	_____
Third	_____	_____	_____

H. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column)

Name	Current Age	Gender	School	Grade	Adjustment Problems?	P?
_____	_____	_____	_____	___	_____	_____
_____	_____	_____	_____	___	_____	_____
_____	_____	_____	_____	___	_____	_____
_____	_____	_____	_____	___	_____	_____

I understand that I am legally responsible for all charges incurred and that there will be a charge for appointments cancelled without a 24-hour notice. I authorize payment of insurance benefits directly to the provider of care, and I authorize the release any medical or other information needed to process payment from insurance.

Signature_____ Date_____