Client Information

Name:_____

Phone: (H)_____(W)_____(Mob.)_____

May I leave you a voice message at these numbers? Yes_____ No_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

May I mail to you at this address? Yes___ No___ May I email you? Yes___ No____

Sex: Male_____ Female_____ Date of Birth:_____

Others living at home:_____

Employer:_____ Position:_____

How long have you been working at this job?_____

Highest level of education attained:_____

Primary physician:_____ Phone:_____

List any significant health concerns:_____

_____

List any medications your are presently taking and the dosage:_____

_____

Have you ever been in therapy before? Yes_____ No_____

If yes, when? _____ Name of therapist:_____

Brief description of issues worked on:_____

_____

Whom may I thank for referring you?_____

Emergency contact:_____

Phone:_____ Relationship to you:_____