Confidential Client Information: **Date:** _____

Name:_____

Phone: (Work) _____ (Home)_____

Cell Phone: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

May I have permission to mail to this address? Yes_____ No _____

Sex: Male_____ Female _____ Date of Birth: _____

Others living at home _____Occupation: _____

How long have you worked there? _____

How long have you worked in this occupation? _____

Education: (List highest level of education attained) _____

Primary Physician: _____ Phone:_____

List any significant health problems: _____

_____

List any medications you are taking and the dosage:

_____

_____

Have you seen this type of therapist before? Yes _____ No _____

If yes, when and with whom? _____

Give a brief description of treatment:

_____

_____

How were you referred to our office? _____

Financially Responsible Person's Information:

Name: _____ Relationship to Client: _____

Phone (if different from above): _____

Address (If different from above): _____

Insurance Carrier (if applicable): _____

Social Security Number of Insured: _____

Group Number: _____ Member Number: _____

Insurance Phone Number: _____