CLIENT INFORMATION QUESTIONNAIRE

Client Name ____ Today's Date __________

Age _______ Date of Birth ______________ Sex _______ Marital Status ____________

Address ____

City, State ________________________________ Zip Code______________________

Email Address ____

Home Phone(   )____________Cell(   )____________Work(   )______________

May we contact you at home? ___________ OK to leave message?____________

May we contact you at work? ____________ OK to leave message?____________

Education _________________________Current Job ____________________________

Employer _________________________ Work Schedule _________________________

Health Insurance

Name of Insurance Company ____

Insurance ID# _______________________ Group# _____________________________

Cardholder's Name ____________________________ Cardholder's DOB ___________

Cardholders Social Security # ____

Address ____________________________________ City, State, Zip ________________

Phone Number (   ) _______________________Employer_______________________

(If Client is a Minor)

Mother's Name _______________________ Father's Name _______________________

Address _____________________________ Address ____________________________

Home Phone _________________________ Home Phone _________________________

Work Phone _________________________ Work Phone _________________________

PLEASE COMPLETE NEXT PAGE

Person to contact in case of Emergency ______________________________________

Address ____________________________________ Phone Number (   ) ___________

Please list all family members and anyone else living with you.

Name	Age	Relationship	Occupation

How did you hear about us?

Briefly describe your reason for visiting us today:

Please list health problems and all medications:

Who is your physician? ____

When was your last Physical? ____

Have you had any previous psychological treatment? When? With whom?

Signature___________________________

Date___________________________