Client Information Form

Client Name_____ New Client? Client Update?
Must be full, legal name of the person being seen for therapy

Address _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number_____ Date of Birth_____ Gender M F

Home Phone _____ Y N
May I leave a message?

Work Phone _____ Y N
May I leave a message?

Other Phone_____ Y N
Please identify May I leave a message?

Client Marital Status
Single Married Other

Client Employed?
Yes No

Client Student Status
Full Time Part Time

Email:_____

How Did You Hear About My Practice? ***Please be as specific as possible***

Former/Current Client Healthcare Professional Yellow Pages Mental Health Provider

Insurance Company Word of Mouth Internet Other Name _____

Responsible Party Information ***The responsible party will receive the bill for any services not covered by insurance. Please only complete information that differs from the client.***

Name_____ Home Phone_____

Address_____ Work Phone_____
Street or PO Box

_____ Relationship to Client:_____
City State Zip