CLIENT INFORMATION

Date of First Appt:_____

Name: _____ Date of Birth: / /

Address: _____ City: _____ Zip: _____

Telephone #--Primary: _____ home__ work__ cell__

Secondary: _____ home__ work__ cell__

Relationship Status: _____ Partner Name: _____

Children: Name _____ Age __ Name _____ Age __

Name _____ Age __ Name _____ Age __

Social Security #: - - Insurance Company: _____

Employer: _____ Policy #: _____

Position: _____ Name of Insured: _____

Please list previous psychotherapy and counseling:

Name and Degree	Location (city, state)	From mo/yr to mo/yr
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any current medical conditions and medications:

Condition	Medication(s)
_____	_____
_____	_____
_____	_____

Emergency Contact:

Name: _____ Relationship: _____

Telephone #s: _____ _____