Client Information

Name:	Today's Date:
Date of Birth:	Occupation:
Street Address:	Employer:
City:	
Zip code:	Work Phone:
Home Phone:	
Cell-phone:	
Referred by:	
Marital Status:	Number of Children:
Number of Previous Marriages:	Number of Children:
Previous therapy? ( )Yes ( ) No	When: How Long?
Reason:	Was it effective?
Previous Therapist:	
Current Medications:	Primary Doctor:
How long:	Address:
Reason:	Telephone:
	Last Physical Exam:
Family History of Mental Illness: ( )Yes ( )No ( ) Unknown	
If yes, who?	
Diagnosis if known:	
Are You Depressed? ( ) Yes ( ) No	
Reason(s) for Seeking Therapy:	
Emergency Contact:	
Telephone Number(s):	
Authorization to Notify During an Emergency?	( ) Yes ( ) No

PLEASE NOTE:
THE PROFESSIONALS WHO SHARE THIS OFFICE SUITE ARE INDEPENDENT AND SOLE PRACTIONERS AND NOT PART OF A GROUP.