Client Information Form

Name: ____

Address: ____

Email address: ______________________ **May we email you? ❍ Yes ❍ No**

Cell number: ______________________ **May we leave a message? ❍ Yes ❍ No**

Date of birth: __________ **Age:** ____

If under 18, name and number of parent or guardian: ______________________

Marital status: ❍ single ❍ married ❍ domestic partnership ❍ separated ❍ divorced ❍ widowed

Name of spouse or domestic partner: ______________________

Please list children and ages: ____

____

Name and number of person to call in case of emergency: ______________________

What do you hope to gain from therapy? ______________________

____

Medical concerns/health issues: ______________________

____

Current medications: ______________________

Special concerns you want therapist to be aware of: ______________________

____

Referred by: ____

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