

## Client Information Form

### Contact Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Is it okay to send mail to this address? Yes/No

Phone Numbers (*please circle the best contact number*):

Home: \_\_\_\_\_ Office: \_\_\_\_\_

Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Is it okay to leave a message at the phone number circled above? Yes/No

Is it okay to send texts to your cellphone? Yes/No

Email Address: \_\_\_\_\_

Is it okay to send email to this address? Yes/No

Marital status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact (Name and Number): \_\_\_\_\_

Who referred you to me? \_\_\_\_\_

What prompted you to call for an appointment?

\_\_\_\_\_

### Medical Information and History:

Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist/Other Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Illnesses, Conditions, or previous Diagnosis Physical or Mental:

\_\_\_\_\_

\_\_\_\_\_

Current Medications and Dosages:

\_\_\_\_\_

\_\_\_\_\_

