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CONFIDENTIAL CLIENT INFORMATION

TODAY'S DATE_____

NAME_____ AGE_____ BIRTHDATE_____ EMAIL_____

ADDRESS_____ APT # _____ HOME PHONE _____

CITY _____ ZIP _____ WORK PHONE _____ CELL _____

EMPLOYER_____ SOC.SEC.# _____

EMPLOYER ADDRESS _____ CITY _____ ZIP_____

( ) SINGLE ( ) MARRIED: HOW LONG?_____ ( ) COUPLED, NOT MARRIED:
( ) SEPARATED ( ) DIVORCED: HOW LONG?_____ HOW LONG? _____
( ) WIDOWED ( ) PREVIOUS MARRIAGES: HOW MANY?_____

PARENT/SPOUSE OR
PARTNER_____ AGE_____ BIRTHDATE _____ EMAIL _____

ADDRESS_____ APT # _____ HOME PHONE _____

CITY_____ ZIP _____ WORK PHONE _____ CELL _____

EMPLOYER_____ SOC.SEC. #_____

CHILDREN:

NAME_____ BIRTHDATE _____ M/F SOC. SEC.#_____
NAME_____ BIRTHDATE _____ M/F SOC. SEC.# _____
NAME_____ BIRTHDATE _____ M/F SOC. SEC.# _____

RESPONSIBLE PARTY *IF*
OTHER THAN YOURSELF _____ RELATIONSHIP TO CLIENT: _____

INSURANCE INFORMATION: *(Please be sure to present insurance card to office staff)* **IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, INCLUDING COPAY AMOUNT AND AUTHORIZATION REQUIREMENTS**.

PRIMARY INSURANCE:

INSURED'S NAME _____ RELATIONSHIP TO CLIENT: _____
INSURANCE COMPANY _____ POLICY/GROUP NO. _____
INSURANCE BILLING ADDRESS _____ INSURED'S I.D. NO_____
_____ INSURED'S BIRTH DATE _____

SECONDARY INSURANCE:

INSURED'S NAME _____ RELATIONSHIP TO CLIENT: _____
INSURANCE COMPANY _____ POLICY/GROUP NO. _____
INSURANCE BILLING ADDRESS _____ INSURED'S I.D. NO. _____
_____ INSURED'S BIRTH DATE _____

FINANCIAL RESPONSIBILITY:
I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED IRREGARDLESS OF INSURANCE COVERAGE.

X_____

Signature of Responsible Party

PLEASE COMPLETE OTHER SIDE

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM.

_____
_____
_____
_____

PLEASE DESCRIBE THE PRESENT PROBLEM:

_____
_____
_____
_____

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH THERAPY?

_____
_____
_____
_____

PLEASE DESCRIBE ANY HEALTH PROBLEMS.

_____
_____
_____
_____

DO YOU SMOKE: ( )YES ( )NO SPOUSE/PARTNER: ( )YES ( )NO

DO YOU DRINK ALCOHOL? ( )YES ( )NO SPOUSE/PARTNER: ( )YES ( )NO
WHAT KIND/HOW MUCH/HOW OFTEN?_____ _____

DO YOU USE ANY OTHER SUBSTANCES? ( )YES ( )NO SPOUSE/PARTNER: ( )YES ( )NO
WHAT KIND/HOW MUCH/HOW OFTEN?_____ _____
(i.e. MARIJUANA, COCAINE, ETC.)

ARE YOU TAKING ANY MEDICATION? ( )YES ( )NO SPOUSE/PARTNER: ( )YES ( )NO
DESCRIBE_____ _____
DO YOU HAVE ANY TROUBLE SLEEPING?( )YES ( )NO SPOUSE/PARTNER: ( )YES ( ) NO
DESCRIBE_____ _____
RECENTLY GAINED ( ) OR LOST ( ) WEIGHT?
HOW MUCH/OVER HOW LONG?_____ / _____

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS?
( )YES ( )NO
DESCRIBE_____

NAME OF PHYSICIAN_____ DATE OF LAST PHYSICAL EXAM_____