Client Data Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who referred you to me?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

C. Your current employer

Employer: _____ Address: _____

Work phone: _____ Calls will be discreet, indicate any restrictions: _____

What is your occupation? _____

D. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

E. Your education and training

Highest grade completed: _____ Other Trainings/certifications: _____

F. Insurance

Policy Holder's Name (if not patient): _____ DOB (if not patient):_____

Insurance company: _____ Customer Service #: _____

Policy/member #: _____ Group #: _____

Social Security #: _____ Co-pay: _____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.