CLIENT INFORMATION SHEET

Name:_____ **Date of Intake:** _____

Sex:_____ **Birthdate:**_____ **Age:**_____

_____

Street Address ***City*** ***State*** ***Zip***

Phone #s (include at least one emergency contact):

Number	***Contact: self, parent, spouse, etc.***	***Type: home, cell, etc.***
(_____)_____	_____	_____
(_____)_____	_____	_____
(_____)_____	_____	_____
(_____)_____	_____	_____

Referred by:_____ **Relation** (PCP, friend, therapist, etc):_____

Primary Insurance:

Company/Plan:_____ **ID#**:_____

Group#:_____ **Name of Primary Insured:**_____

Birthdate of Primary Insured:_____ **Relation to client:** _____

Address of Primary Insured (if different from above):_____

Secondary Insurance (if any):

Company/Plan:_____ **ID#**:_____

Group#:_____ **Name of Primary Insured:**_____

Birthdate of Primary Insured:_____ **Relation to client:** _____

Address of Primary Insured (if different from above):_____

Family Information (list any relations who may be referenced, or included, in therapy):

Name	**Relation:**	**Age:**	**Profession:**	**Living Situation:**

Current Life Situation (job, school, at-home parent, unemployed, etc):_____ _____

_____

Any special family circumstances (adoption, foster care, divorce):_____

_____

_____

_____

PCP INFORMATION

Doctor's Name/Practice: _____

_____

Street Address *City* *State* *Zip*

Phone: _____

CURRENT MEDICATIONS

Med Name: Dosage: Date Started

SCHOOL INFORMATION (for school-age clients)

Current School:_____ Grade: _____

_____

Street Address *City* *State* *Zip*

Contact Person: _____ Phone: _____

Any Current Support Services (IEP, 504 plan, Special Education, etc.):

Service: Date/Grade Started: Description: