CLIENT INFORMATION SHEET OFFICE USE ONLY

Today's Date_____

Name_____Sex_____Age_____Birthdate_____

Address_____zip _____

Phone (home)_____(work)_____(cel)_____
Email address_____
Currently:
Married____Separated_____Divorced____Widowed_____Cohabiting_____

Length of present marriage/ relationship_____Total time known_____

Referred by_____Agency_____

Address/Phone_____

Employed Yes___No___Full time___Part time____Length of empl._____

Employer_____Occupation_____

Primary Care Physician_____Last seen_____
Gynecologist_____Last seen_____
Urologist_____Last seen_____
Psychiatrist_____Last seen_____
Have you ever received some form of counseling? Yes_____-No_____
If yes, names and dates of therapists/counselors_____
_____
Household members living with you now, Please list names, ages relationship.__
_____

INSURANCE INFORMATION: Name of carrier_____
Policy #_____ID#_____Group#_____

Social Security #_____Telephone # to verify coverage_____

BREIFLY LIST THE CONCERNS WHICH BROUGHT YOU TO THERAPY: