

**◆ New Client Information Form ◆**

CLIENT NAME \_\_\_\_\_ THERAPIST \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SSN: \_\_\_\_\_ GENDER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ OTHER PHONE \_\_\_\_\_ MARTIAL STATUS \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_

So your psychologist can send additional information to you.

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE # \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REFERRED BY \_\_\_\_\_

REASON FOR REFERRAL \_\_\_\_\_

.....

INSURANCE \_\_\_\_\_ POLICY # \_\_\_\_\_ GROUP# \_\_\_\_\_

CARD HOLDER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

.....

**(Adult Client is considered responsible for his/her own account. The responsible party for a child's account rests with the parent seeking services, unless an agency/court/school has guaranteed payment.)**

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*The above information is accurate and complete to the best of my knowledge*

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Please Check Problem Areas:**

<input type="checkbox"/> Alcohol & Drugs	<input type="checkbox"/> Grief/Loss Issues	<input type="checkbox"/> Parent/Child Conflict	<input type="checkbox"/> Sexual Abuse/Rape
<input type="checkbox"/> Anger/Rage	<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Problems with the Law	<input type="checkbox"/> Sexual Concerns
<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Relationships with Friends	<input type="checkbox"/> Sleep Disturbance
<input type="checkbox"/> Appetite/Eating Problems	<input type="checkbox"/> Lying	<input type="checkbox"/> Relationships with Parents	<input type="checkbox"/> Stealing
<input type="checkbox"/> Attention Problems	<input type="checkbox"/> Marriage Problems	<input type="checkbox"/> Relationships with Work	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Depression	<input type="checkbox"/> Money/Finances	<input type="checkbox"/> Religion Issues	<input type="checkbox"/> Weight Problems
<input type="checkbox"/> Fears	<input type="checkbox"/> Pain	<input type="checkbox"/> Repetitive Thoughts/Actions	