Client Confidential Information

Please <u>PRINT</u> your answers. This information will not be released to any unauthorized person or agency.

Date: _____/_____/_____, Insurance Co. _____, ID#:_____

Copay Amount?_____, Do you have a deductible, if so how much? _____

Sex: { }M, { } F, D.O.B. _____/_____/_____, if EAP-Authorization***#_____***

Member Last, First Name: _____, ***Tel:# _____,***

Address:_____, City: _____, Zip: _____,

Religion (optional) _____

Martial Status: { } Married { } Single { } Divorced { } Separated { } Widow(er)

If couple list names of people in therapy with you and their relationship to you (if applicable):

1. _____ Relationship: _____DOB____/____/_____

2._____ Relationship:_____DOB____/____/_____

Emergency Contact:_____ Tel:#_____, Relation:_____

Employed?: { } Yes, { } No, Occupation: _____, Date last worked:____/____/____

Are you under the care of a Psychiatrist?, _____

Do you have Physical Handicaps? { } Yes { } No - If yes, specify: _____

Do you take medications?(if yes please list)_____

_____

Reason for coming to therapy?_____

_____

THANK YOU