Client Information Form

Name ____ Date of Birth _________________ Age _________

Home address _____________________________________City ______________________ zip __________

How did you find me? (please be as specific as possible) ____

Please list your contact information and check a box to indicate how you prefer to be contacted:

☐ Cell: (   )__________________ OK to leave a message? ________

☐ Home/other: (   ) ___________________ OK to leave a message? ________

☐ Email Address _____________________________________ OK to email you? _____

Emergency Contact Name: _____________________________________

Phone #: (   ) ___________________ City & state: ____________________

Relationship to you: ____

Have you ever had psychotherapy or other mental health treatment before? _____________________________________

____

Have you ever been hospitalized for a psychiatric (mental health) reason? ☐ Yes ☐ No ☐ I'm not sure

Who is your health insurance provider - even if you don't intend to use it? (Just the name of the insurance company)

____

What psychiatric medications do you take, if any? Who is the prescribing physician? Have you ever taken psychiatric medications?

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Credit card info (to secure your sessions)

Please provide at minimum 48 hours notice (2 full business days) for cancellations and rescheduling sessions.

Sessions cancelled or rescheduled with less than 48 hours notice will be charged to your credit card.

Number ______-______-______-______ Exp ____/____ Security Code _______ Billing Zip ________

Your signature below authorizes me to run a $1 reimbursable test charge on the Square credit card reader.

Client Signature: _________________________________ **Date:** ___________________