NEW CLIENT INFORMATION FORM

CLIENT INFORMATION (Please Print)

Name: _____ Birth Date: _____
(Last) (First) (Middle) (Month/Day/Year)

Address: _____
(Street or PO Box) (Apt) (City, State) (Zip)

Home Phone: (_____)-_____ Cell/Other(_____)-_____

OK to Call? (Y/N) OK to leave message? (Y/N)

Sex _____M _____F

Social Security Number: ____-___-_____ Occupation: _____

E-Mail _____ Marital Status: _____

PLEASE COMPLETE THIS SECTION IF THE PATIENT IS A MINOR

Father's Name _____ DOB _____ Legal Guardian? Y/N

Address: _____Phone (___)_____

Mother's Name _____ DOB _____Legal Guardian? Y/N

Address: _____Phone (___)_____

Legal Guardian(if different then above):_____

Address: _____Phone (___)_____

Signature of person completing form: _____ Date:_____

Social Security Number: ____-___-_____ Relationship to the child: _____

EMPLOYER/SCHOOL INFORMATION

Employer (School): _____ Length of Employment/Grade:_____

Employer (School) Address_____
(Street or PO Box) (City, State) (ZIP)

EMERGENCY CONTACT

Emergency Number: (____)-_____ Name/Relationship: _____

OTHER CONTACTS:

ATTORNEY:

Name: _____ Telephone Number: (_____)-_____

Address:_____
(Street or PO Box) (City, State) (ZIP)

MENTAL HEALTH PROVIDER:

Name: _____ Telephone Number: (_____)-_____

Address:_____
(Street or PO Box) (City, State) (ZIP)

OTHER (PLEASE SPECIFY):_____

Name: _____ Telephone Number: (_____)-_____

Address:_____
(Street or PO Box) (City, State) (ZIP)