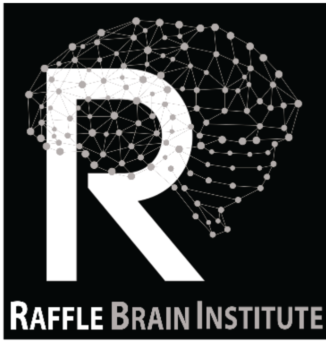

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CLIENT INFORMATION SHEET

Date of First Session: _____/_____/_________ Referral Source____

First Name______________________ MI_____ Last Name_____________________________

Address____

City____Zip___________________

DOB: _____/_____/_________ SSN_______-_____-_________

Birth Country (If Born Outside U.S.)_____________________ Year of U.S. Entry_______________________

Home Phone (______)______-________ Cell Phone (______)______-________

E-Mail_______________________________ Handedness: Right _______ Left ________

Gender:____ Sexual Orientation ______________ Ethnicity______________ Primary Language____________

Highest Education __________________ Educational Focus/Degree___________________________________

Marital Status: Single ______Married (year)_________ Divorced (year)________ Widowed (year)__________

Emergency Contact (If Patient Child/Conserved, Name of Parent, Guardian, or Conservator):

Name________________________________ Phone (_____)_____-_______ Relationship:_________________

Address____

E-Mail_______________________________

Insurance Company____ Plan Type_________________________

Address____ Phone (_____)_____-_______

ID Number___________________________ Group Number____________________

Insured Name_________________________Insured DOB:_____________Insured SSN___________________

Secondary Insurance____________________________________ ID Number___________________________