Client Confidential Information

Please ***PRINT*** ***your answers to the following questions. This information is for the use of this agency only, and will not be released to any unauthorized person or agency.***

Date: ____

Insurance CO. name and Member ID# (not group):____

____ ***Sex: { }M, { } F,***

D.O.B. ____/____/______ ***if EAP - Authorization#***____

Member Last, First Name: ____

Maiden:______________________________________***Address:***____

____ ____***City:*** ____

Zip: _________________

Alternate Address:____

Telephone:# _______________________________, ***Religion (optional)*** _________________________________

Emergency Name:______________________________________ ***Contact:#***______________________________

Relationship:___________________________________

(Name)

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

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

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

1. ___________________________________ ***Relationship:*** ______________***DOB***_______/______/___________

2. ___________________________________ ***Relationship:*** _____________ ***DOB***______/_______/___________

3. ___________________________________ ***Relationship:*** _____________ ***DOB***_____/_______/____________

4. ___________________________________ ***Relationship:*** _____________ ***DOB***_____/_______/____________

Employed?: { } Yes, { } No, Occupation: ________________________________, ***Date last worked***:_________

If not employed how do you support yourself? (Explain):____

____

Are you under the care of a Medical Doctor or Psychiatrist? (if so please provide name and telephone)____

Do you take medications?(if yes please list dose and purpose)____

____

Reason for coming to therapy?____

____

____

THANK YOU