

Client Information Request

Date: _____

First Name _____ Last Name _____

Date of Birth: _____ Email Address: _____

Parent(s) name(s) _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Insurance Company _____ Insurance ID# _____

How did you hear about us? _____

Are your parents: ☐ Single ☐ Married/Cohabiting ☐ Separated ☐ Divorced ☐ Widowed

What school do you attend?: _____

What are your current grades?: _____

Do you have an IEP (provide details)? _____

What is the primary reason that brought you into therapy today?

What medications (if any) are you currently taking? _____

Do you have a history of:

☐ Depression ☐ Anxiety ☐ Abuse/Trauma ☐ Difficulty With Parents ☐ Drug/Alcohol Abuse

Please describe any other concerns that you would like me to know about immediately: _____