

NEW CLIENT INFORMATION SHEET

REASON FOR VISIT: _____

CLIENT'S NAME: _____

Today's Date: _____

Name of Guardian(s) (if Minor): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Client's Birth Date: _____ Client's Age: _____ Client's SSN: _____

CONTACT INFORMATION:

Home Phone: (_____) _____ Work Phone: (_____) _____

Mobile Phone: (_____) _____ Email Address: _____

OTHER PEOPLE LIVING IN CLIENT'S HOUSEHOLD:

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELATIONSHIP STATUS: Single Married Separated/Divorced (Single)
 Divorced (Remarried) Widowed Other _____

CURRENT MEDICATION: _____

REFERRING PROVIDER OR AGENCY: _____

PREVIOUS PSYCHOLOGICAL TESTING (dates, reason for testing):

PREVIOUS MENTAL HEALTH TREATMENT (psychotherapy, counseling, medication, hospitalization):

