CLIENT INFORMATION

Date_____

Client Name_____

Marital Status_____

Street Address_____ City_____ State_____ Zip_____

Birthdate _____

Phone (home)_____ (work)_____

If someone other than the client is responsible for the bill, provide name, address, employer, **and signature** of person responsible:

_____

Name of person to be contacted in case of emergency_____

Relationship to client_____

Phone(h)_____(w)_____

Who referred you to me?

Name_____Address_____

Phone_____

Sign on next line to give permission to send a thank-you note or call to the referring person

_____

Sign here to give permission to exchange relevant clinical information***** with the

referring person _____

If not referred, how did you find me? _____

Primary care Physician_____

Address_____ _____Phone_____

_____

Sign here to give permission to exchange clinical information***** with this physician:

*****(Treatment summaries, progress reports, and phone contact as needed)