

CLIENT INFORMATION FORM

Today's Date: _____

PATIENT INFORMATION

Last Name		First	Middle	Title	Marital Status
_____		_____	_____	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	<input type="checkbox"/> Single, never married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Date of Birth	Age	Sex	Referred by		
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____		
Street Address				Primary Phone <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	
_____				_____	
City		State	ZIP Code	Alternate Phone <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	
_____		_____	_____	_____	
Email Address			Email reminders	NOTE: Appointment reminders are sent as a courtesy. 24 hours notice is required for appointment cancellations. If you are unable to provide 24 hours, you will be responsible for the session fee.	
_____			<input type="checkbox"/> Y <input type="checkbox"/> N		
Occupation:		Employer	Employer's Phone No.		
_____		_____	_____		

PARTNER/SPOUSE INFORMATION (if applicable)

Last Name		First	Middle	Title	Marital Status
_____		_____	_____	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	<input type="checkbox"/> Single, never married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Date of Birth	Age	Sex			
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F			
Street Address				Primary Phone <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	
_____				_____	
City		State	ZIP Code	Alternate Phone <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	
_____		_____	_____	_____	
Email Address:			Email reminders	NOTE: Appointment reminders are sent as a courtesy. 24 hours notice is required for appointment cancellations. If you are unable to provide 24 hours, you will be responsible for the session fee.	
_____			<input type="checkbox"/> Y <input type="checkbox"/> N		
Occupation:		Employer	Employer's Phone No.		
_____		_____	_____		

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:	Relationship	Primary Phone <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	Alternate Phone <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M
_____	_____	_____	_____

RESPONSIBLE PARTY

Name (please print):	Address (if different)
_____	_____

PAYMENT IS REQUIRED AT THE TIME OF SERVICE: All professional services rendered are charged directly to the patient and each patient is responsible for the payment fees. Services are not rendered on the basis insurance will pay all fees. Any financial concerns should be discussed with the Therapist.

I HAVE READ THE ABOVE STATEMENT AND AGREE TO BE PERSONALLY RESPONSIBLE FOR ALL CHARGES AND FEES. ADDITIONALLY, I GIVE MY CONSENT FOR TREATMENT.

In agreement _____
 Patient Signature _____ Date _____ Partner/Spouse Signature (if applicable) _____ Date _____