

CLIENT INFORMATION SHEET

1. **Your Name** _____ **Date** _____
2. **Age** _____ **Date of Birth:** _____
3. **Email:** _____
4. **Address** _____
5. **Parents names & Ph#'s** _____
6. **Phone Number Home** _____ **Work** _____
7. **Address** _____
8. **Name, Address, and Phone Number of Primary care Physician.** _____
9. **Insurance company** _____
10. **What is your occupation?** _____ **How long?** _____
11. **Are you a. married** ____ **b. divorced?** ____ **c. single** ____ **d. loss of spouse through death?** _____
12. **Married how long?** _____ **How many times have you been married?** _____
13. **Are you involved in a significant relationship which is not marriage?** _____
14. **How long and what is the nature of the relationship?** _____
15. **Do you have children?** _____ **How many?** _____
16. **What are their ages and sexes?** _____
17. **How many siblings do you have?** _____
18. **What are their ages and sexes?** _____
19. **What is your birth order?** _____
20. **Who refereed you to me, or how did you hear about my work as a therapist?** _____

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