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Ph: 415-690-8208

CLIENT'S NAME ______________________________ AGE ________ DOB ____________________

ADDRESS ____________________________________ CITY/STATE ______________________

ZIP CODE ____________________

ETHNICITY ______________________ E-MAIL ADDRESS ______________________________

HOME TELEPHONE ______________________ CELL PHONE ______________________________

BUSINESS PHONE ______________________ OCCUPATION ______________________________

NAME OF EMPLOYER ____

PREFERRED FORM OF CONTACT (& ANY PRIVACY RESTRICTIONS) ______________________

EDUCATION/ DEGREE ______________________________ MARITAL STATUS ________________

NAME & AGE OF CHILDREN ____

CURRENT LIVING SITUATION ____

DESCRIBE ANY HEALTH PROBLEMS ____

MEDICATIONS YOU TAKE & DOSAGE ____

DOCTOR'S NAME AND PHONE NUMBER ______________________ (________)________________

PSYCHIATRIST'S NAME AND PHONE NUMBER __________________ (________)________________

IN YOUR FAMILY (INCLUDING YOURSELF) WAS/IS THERE: *(write on back if need more space)*

ALCOHOLISM? YES/NO (IF YES) DESCRIBE: ____

SUBSTANCE ABUSE? YES/NO (IF YES) DESCRIBE: ___________________________________

MENTAL ILLNESS? YES/NO (IF YES) DESCRIBE: ____________________________________

____

SERIOUS ILLNESS? YES/NO (IF YES) DESCRIBE: ____________________________________

SIGNIFICANT DEATHS? INCLUDE APPROXIMATE DATE: _______________________________

____

IF USING INSURANCE, PLEASE PROVIDE THE FOLLOWING:

NAME OF PRIMARY POLICY HOLDER ______________________________ DOB ________________

EMERGENCY CONTACT NAME/RELATIONSHIP ____

EMERGENCY CONTACT PHONE (____)____________________

HOW DID YOU HEAR ABOUT MY SERVICES? ____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

SIGNATURE: ________________________________ DATE: ______________________