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310-861-2000

## Client Information For: **Date:** _____

Client Name _____

Address _____

Home Phone #_____ Okay to leave a private message on this #?_____

Cell Phone # _____ Okay to leave a private message on this #?_____

Email address _____ OK to email? Yes/No

Date of Birth _____ Age____ Gender_____

Primary Physician _____ Physician Phone_____

Relationship status (circle one): Single Married/Partner Separated Divorced Widowed

Occupation:_____ Employer _____

Have you ever had previous psychological services (therapy or psychiatry) _____

If yes, previous therapist/practitioner: _____

_____

Person to contact in case of emergency: _____

Relation to client_____ phone # _____

## If client is a minor:

**Mother's name** _____

Phone # _____ Is it okay to leave a private message on this #?_____

Home Address _____

Email address _____ OK to email? Yes/No

**Father's name** _____

Phone # _____ Is it okay to leave a private message on this #? _____

Home Address _____

Email address _____ OK to email? Yes/No

For the treatment of minor children, if you are separated or divorced please describe child's custody/living arrangements. _____

_____

_____

Please list names and ages of people living in the child's home. _____

_____

_____

_____

Current Grade _____ School Attending _____

Are you/client currently taking any prescription or over-the-counter medication?

□ Yes □ No

If Yes, Please list them here: _____

_____

_____

_____

Please tell me what brings you in today: _____

_____

_____

_____

How did you hear about my practice? If someone referred you please let me know so that I may thank them. _____