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Licensed Psychologist
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New Client Information

Thank you for filling out the information below. It will allow me to serve you better and more efficently.

Today's Date: ________________________________

Client Name:________________________________

Client Gender: MALE FEMALE

Client Date of Birth:_______________Age:________

Client Social Security #:________________________

Client Yrs. of Education:_______________________

If Client in school, name:_______________________

Relationship to Client: SELF PARENT/GUARDIAN

if the Parent, name?___________________________

Home Address:______________________________

____

____

Home Phone: ______________________________

Cell Phone: _______________________________

INSURANCE: ____________________________

***Insured's* Name:** ___________________________

*Insurance ID Number:*_________________________

Insurance Group Number:______________________

Insured's SS #:______________________________

Insured's Date of Birth:_______________________

Certification # ?: ____________________________

Occupation: _______________________________

Employer: ________________________________

Employer Address: ___________________________

____

Work Phone: _______________________________

Primary Care Provider (family doctor):__________________

PCP Practice: ______________________________

PCP Address: ______________________________

____

PCP Phone:_________________________________

Client/Family Job/School Problems: YES NO

List:_______________________________________

List:_______________________________________

Client/Family Legal Problems: YES NO

List:_______________________________________

List:_______________________________________

Client/Family Health Problems: YES NO

List:_______________________________________

List:_______________________________________

Client currently taking any medication? YES NO

List:_______________________________________

List:_______________________________________

List:_______________________________________

Client Marital Status: Sing Mar Div Wid Coh

Name if spouse or partner: ____________________

Client Household Members (name / age / gender):

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____

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____

____

Children Elsewhere (of adult client, or, siblings of minor)

____

____

____

Annual Family Income:________________________

Is it ok for the *PCP* (family doctor listed) to be informed of your starting services here? It is a good idea and should be done! YES REFUSED *(mark one!)*

Signed:_____________________________________