Client Information Form

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Highest level of education completed: _____

Marital status: _____ Spouse's Name (if applicable): _____

Children's Names and Ages (if applicable): _____

_____

Name of Emergency Contact: _____ Phone Number: _____

Are you in (or expected to be in) litigation? _____

What are your reasons for coming here?_____

_____

Have you participated in psychotherapy or a psychological evaluation before? (please mention if in school or outside provider, as well as estimated dates)_____

Have you ever been diagnosed with a psychological concern/illness? If so, which one(s)?

_____

Do you have any medical conditions?_____

Do you take any medications, and for what reasons?_____

_____

How were you referred to this office? (if online, please specify the site if possible)

_____

Will you be seeking insurance reimbursement for these services? _____

(IF YES)

Would you like for it to be emailed to you? If so, to what address: _____

Is there any other information that Dr. Saul should know about in order to treat you effectively? (please use back if needed)_____

_____