Client Data Sheet

**Elizabeth Wittenberg, JD, LICSW**

**2610 University Ave. West, Suite 475**

**St. Paul, MN 55114**

**Client Information:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Last First Middle Maiden

Age: \_\_\_\_ Date of Birth: \_\_\_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Chosen Pronoun:\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  Street   |   | City State Zip  |
| Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |   | OK for Message? Yes \_\_\_ No \_\_\_\_  |
| Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |   | OK for Message? Yes \_\_\_ No \_\_\_\_  |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |   | OK for Message? Yes \_\_\_ No \_\_\_\_  |
| Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |   | OK for Message? Yes \_\_\_ No \_\_\_  |
| Relationship Status:  |   | Employment Status:  |
| \_\_\_\_ Single  |   | \_\_\_\_ Employed Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_ Married  |   | \_\_\_\_ Unemployed but seeking employment  |
| \_\_\_\_ Separated \_\_\_\_ Divorced  |   | \_\_\_\_ Unemployed but not seeking  |
| \_\_\_\_ Widowed \_\_\_\_ Unmarried \_\_\_\_ Partnership  |   | Current Student? Yes \_\_\_ No \_\_\_\_  |

Do you have health insurance? Yes \_\_\_\_ No \_\_\_\_

Name of health insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your medical care:** From whom or where do you get your medical care?

Clinic/doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you enter treatment with me for problems, may I contact your physician so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant other/nearest friend or relative not residing with you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family-of-origin history**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relative  | Name  | Current age (or age at death)  | Illness or cause of death  | Education  | Occupation  |
| Father  |   |   |   |   |   |
| Mother  |   |   |   |   |   |
| Siblings  |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
| Step- or Grandparents  |   |   |   |   |   |

**Current family or people you live with**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relative  | Name  | Current age  | Illnesses or concerns  | Education  | Occupation  |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date: