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: