Client Data Sheet

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Client Information:

Name: ____
Last First Middle Maiden

Age: ____ Date of Birth: _______ Soc. Sec. (last 4) #: __________ 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:
____ Single
____ Married
____ Separated
____ Divorced
____ Widowed
____ Unmarried
____ Partnership

Employment Status:
____ Employed Where? ______________
____ Unemployed but seeking employment
____ Unemployed but not seeking

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