

_____ If therapist
is unable to reach you, is it OK to contact your spouse/partner? YES __ No_

Employment School Status

Are you currently employed? YES _____ NO _____

Are you currently enrolled in school? YES _____ NO _____ If yes, please specify:

Full-time Part-time Retired Seasonal Unemployed Other: _____

If yes, please specify:

Full-time Part-time Non-credit courses Trade/vocational Other: : _____

Employer Name: School/University Name:

EMERGENCY CONTACTS Please list at least ONE person that can be contacted by your therapist in the event of an emergency.

Name: _____

Ok to leave message? _____ Address: _____

YES _____ NO _____ Phone: _____

Relationship to you: _____

Name: _____

Address: _____

Phone: _____

PRIMARY CARE PHYSICIAN

Current Physician Name: _____

Address: _____

Phone: _____

Fax Number _____

Date of last physical exam: _____

REFERENT INFORMATION By whom were you referred? Phone:

Consent for Release of Information By signing below, I am authorizing my Protected Health Information (PHI) to be used and disclosed to my insurance company or other private payors for billing purposes.

Client Signature

Date

Witness/Therapist

Date
