DJB THERAPEUTIC SOLUTIONSLLCCLIENT INFORMATION SHEET

Today's Date: _____

Name: _____ Date of Birth: ___/___/___

Age: _____ Social Security Number: ____/____/____

Home Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Is it ok to send mail to this address? _____

Home Phone: _____ is it ok to leave a message at this number? _____

Cell Phone: _____ is it ok to leave a message at this number? _____

Email address: _____ is it ok to send email to this address? ____

*In case of an emergency, please provide the name and number of the person you would like me to contact.

Emergency Name: _____ Phone: _____

Relationship to You: _____

Health Insurance Provider: _____ Member ID#: _____ Plan/Group#_____
Co-Pay: _____ Deductible: _____ Authorization#: _____

Mental-health services received in the past or currently? _____
Please specify approximate dates, type of service, therapist names. Continue on reverse as needed.

Psychiatric medication? Current: _____ Past: _____

Other medical conditions: _____

Who referred you to me? _____

Please briefly describe your chief concerns at this time: _____

_____

_____

_____

Please describe any past experiences with psychotherapy, positive or negative, that you'd like me to know about:

_____

_____