

Client Information

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell Phone: _____ Emergency Phone: _____

Calls will be discreet, but please indicate any restrictions _____

Email: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No

How did this person explain how I might be of help to you?

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

Clinic/doctor's name: _____ Phone: _____

Address: _____

D. Emergency Contact: Identify individual to contact in case of an emergency:

Name/Relationship _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____