

**Client Name**

First name	Middle	Last	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address		Email address	
City	State	Zip	Date of Birth
Home phone <input type="checkbox"/> Preferred contact #		<input type="checkbox"/> Work / <input type="checkbox"/> Cell <input type="checkbox"/> Preferred contact #	

**Spouse or Parent/Guardian (if client is less than 18 yrs of age)**

First name	Middle	Last
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**Children/Sibling information**

Name	Birth date	Name	Birth date

**Financial Responsibility (if different from Client)**

First name	Middle	Last	Relationship to client
Street address			
City	State	Zip	
Home phone <input type="checkbox"/> Preferred contact #		<input type="checkbox"/> Work / <input type="checkbox"/> Cell <input type="checkbox"/> Preferred contact #	

**Reason for seeing a therapist today**

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**Medical History**

Current medications		
Current and previous health problems		
Physician	Office contact #	
Signature	Print name	Date