crossroads Institute for Psychotherapy and Assessment

CLIENT INFORMATION

Name of client:_____ DoB and age:_____

For a minor, parents/guardians:_____

Address where mail can be sent: _____

_____

Phone where a message can be left:_____ Cell:_____

Email address where you can receive emails:_____

Emergency Contact: _____

Employer/School:_____ Occupation/grade:_____

Client living with (name, relationship and age):_____

_____

Financially responsible party:_____

Relationship to client:_____

Address and phone number, if different from above:_____

_____

Insurance company and policy number:_____

Referred by:_____

Primary care physician name and address/phone number:_____

_____

Psychiatrist, if any, name and phone number:_____

Other healthcare providers:_____

Current medications:_____