



**CLIENT INFORMATION SHEET
(ADULTS/COUPLES)**

Date: _____

Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

City & Zip: _____ **Work Phone:** _____

Soc. Sec. #: _____ **E-mail:** _____

Birth Date: _____ **Best way to reach you?** _____

Employer: _____ **Job Title:** _____

Spouse/Partner: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

City & Zip: _____ **Work Phone:** _____

Soc. Sec. #: _____ **E-mail:** _____

Birth Date: _____ **Best way to reach you?** _____

Employer: _____ **Job Title:** _____

Child: _____ **Birth Date:** _____

Child: _____ **Birth Date:** _____

Child: _____ **Birth Date:** _____

Child: _____ **Birth Date:** _____

| | | |
|-----------------------------------|------------------------------------------------|----------------------------------------|
| Marital Status: | Employment Status: | Patient's Condition Related To: |
| <input type="checkbox"/> Single | <input type="checkbox"/> Employed Full-Time | Self: Yes No |
| <input type="checkbox"/> Married | <input type="checkbox"/> Employed Part-Time | Family Matter: Yes No |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Student | Marriage: Yes No |
| <input type="checkbox"/> Other | <input type="checkbox"/> Not Currently Working | Other: _____ |

Referred by: _____

Prior Therapist: _____

Primary Care Physician: _____ **Phone #:** _____

In case of emergency notify: _____ **Phone #:** _____

Therapist you are seeing at LIFE: _____