

JANIS B. RICE, M.A., L.P.C.

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CLIENT INFORMATION FORM

TODAY'S DATE: _____

CLIENT:

NAME: _____ SS#: _____

SEX ___ BIRTH DATE: _____ AGE: _____

If Minor, PARENT(s)/GUARDIAN(s): _____

ADDRESS:

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

PHONES / EMAIL:

(Home) _____ (Cell) _____

(Work) _____ (OK to Call at Work?) (Leave Voice Messages OK?)
YES / NO YES / NO

(Email) _____ (OK to Email?)
YES / NO

Want appointment reminder? YES / NO - If YES (circle): by Phone: (Home) (Cell) (Work) or (Email)

CLIENT'S

EMPLOYER/

SCHOOL: _____ OCCUPATION: _____ HIGHEST LEVEL EDUCATION _____

INSURANCE COMPANY: _____ PHONE: _____

PRIMARY INSURED:

NAME: _____ BIRTH DATE: _____

INSURED'S

EMPLOYER: _____ WORK PHONE: _____

INSURANCE ID#: _____ SS#: _____

SPOUSE/PARTNER:

NAME: _____

RELATIONSHIP STATUS: () Single () Married (years) _____ () Separated () Divorced () Widowed

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____ REFERRED BY: _____

FAMILY INFORMATION: List everyone living with Client: (Spouse, Children, Parents, Relatives, Others)

NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP
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MEDICAL INFORMATION:

Primary Care Physician: _____ PHONE: _____

Other Physicians Treating You: _____ PHONE: _____

Current Medications: _____