CLIENT INFORMATION SHEET

Ashleigh Bryan, MS, LMFT
5200 Park Rd, Suite 111
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Important information in order for me to work with you:

CHILD'S NAME(1):____

PARENT/GUARDIAN NAME(2):____

ADDRESS:____

CITY:_________________________________ST:_______ZIP:__________________

BILLING ADDRESS:____

CITY:_________________________________ST:___________ZIP:______________

PHONE 1: DAY
(______)______________________________EVE(______)______________________

PHONE 2: DAY
(______)______________________________EVE(______)______________________

E-MAIL 1: _______________________________________

E-MAIL 2: ____________________________________

DATE OF BIRTH: (CHILD)______________________(PARENT)_________________________

Instructions regarding contacting you concerning scheduling and other matters:

PHONE NUMBER, IF ANY, WHERE WE ARE AUTHORIZED TO LEAVE A
MESSAGE IDENTIFYING THERAPIST'S NAME AND NUMBER:

HOME___________________WORK__________________CELL__________________

Referral Information:

Referral Source:

Name Agency Telephone #

Referred To: ____

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A CONTACT PERSON IN CASE OF EMERGENCY:
NAME:____Relationship____________________

DAY(_______)_______________________EVE (_______)_________________________

Insurance Information:

WILL YOU BE USING YOUR INSURANCE? YES ___ NO ____ INSURANCE COMPANY:___________________

MEMBER ID NUMBER: _____________________ NAME OF INSURED:___________________________

DOB OF INSURED:_______________________ INSURANCE PHONE #:_________________________

Are you or any family members in therapy now? YES _____OR NO _____

Previously? If so, when, with whom, and for what reasons?

DO YOU WANT THE THERAPIST TO TALK WITH A PREVIOUS THERAPIST(S)?

IF YES: GIVE ADDRESS:____

& PHONE NUMBER:____

SIGNATURE For Consent:________________________________

DATE:_______________

LENGTH OF PERMISSION:__________________________

SIGNATURE For Consent:___________________________________DATE:__________________

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• Family Information: Start with all family members, and nonmembers, who live in the household and then include those outside the household that may also participate in the therapy.

Family/Other Members:	Ages:	Relationship To client:	√Members here today

• Have any family members had problems with drugs and/or alcohol? Have they received treatment? Are they currently using?

• Are you or any family members taking prescribed medications? What are they and what are they being taken for?

• Are any of those who will be coming for therapy involved in divorce proceedings? If so, who has sole custody or is there joint custody of the minor children?

• Are you, or is anyone else in your family, experiencing thoughts of harming oneself or someone else?

• Have you or anyone in your family experienced instances of physical violence now or in the past?

• Have you had problems with natural disasters (i.e., flood, hurricane) or another traumatic event?

• Do you have any special needs regarding therapy, such as a physical disability?