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Integrative Psychotherapy Offices
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New Client Information Form

Name:_____

Date of first visit_____ Age_____

Address:_____

Phone #'s Home_____ Work_____Cell_____

Date of Birth_____ SS#_____

Employer_____Position_____

Referred by_____

Relationship to you _____

In case of emergency, notify:_____

Relationship to you_____Telephone_____

MEDICAL

Do you have any medical problems? Please explain.

If you are currently under the care of a physician for a continuing health problem, please give me your physician's name and phone number:

_____

Do you take regular medications? If so, please list:

Medication:_____
Dosage:_____
Frequency:_____

Do you smoke? Yes No
If yes, how much?

Do you drink alcoholic beverages? Yes No
If yes, how much?

Previous Mental Health Services

Types of Services: _____

Provider:_____

Dates of Services:_____

Current or expected legal involvement? Yes No
If yes, please explain

Briefly describe the reason or situation for which you are seeking therapy:

Briefly explain the goals you would like to accomplish in therapy:
(use other side to elaborate)

PAYMENT & INSURANCE

Financially Responsible Party: Self ___Other _____

Please provide the information regarding insurance(s) and/or health plan(s) to be utilized:

Primary Insurance Company:_____

Name of Policy Holder:_____

Subscriber ID#_____

Group #_____

Insured's Date of Birth:_____

I authorize the release of any clinical or other information necessary to process my insurance claim.

Signature _____Date_____