NEW CLIENT INFORMATION FORM

Please provide the following information and answer the questions below.

Client Information

Date: _____

Name: _____

Home Phone: _____ Cell Phone: _____

Best time to call?_____

Is it okay to leave messages at these numbers? □ Yes □ No
If no, please list which number it is okay to leave a message_____

E-Mail Address: _____

Address: _____
Street Address

_____
City State Zip

How long have you been living at this address? _____

Occupation: _____

Date of Birth: _____

For appointment scheduling, what are the best:

Times of day:_____

Days of the week:_____

Relationship Status:
□ Never Married □ Married □ In Relationship □ Divorced □ Widowed

Emergency Contact Information:

Name: _____

Relationship: _____

Phone: _____

Please list the names and relationships of the five most important people in your life:

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have pets? □ Yes □ No

If yes, please list: _____

Education: _____

How would you rate your overall physical health?

□ Excellent □ Great □ Good □ Fair □ Poor

Do you have any sleep problems? □ Yes □ No

If yes, please describe:_____

_____

_____

Are you currently taking any medications? □ Yes □ No

If yes, please list:

_____

_____