Client Background Information Form

CLIENT INFORMATION

NAME (last, first, middle)	Birth date Age	Today's date
Street Address	Social Security number	Gender ☐ Male ☐ Female
City State Zip code	Cell phone	Work phone
Employer or school	Occupation or grade	Referred by
Past and present health problems	Physician's name	Physician's phone #
Current medications	Emergency contact name and phone # (if different than person named below)	

Marital status	Date of current marriage	Dates of previous marriage(s) and divorce(s)	Email

SPOUSE / PARTNER NAME (Last, first, middle)	Birth date Age	☐ Spouse ☐ Partner
Employer / Profession	Cell phone	Business phone
Presenting problem		

If the client is a MINOR, list parents' information below

Relationship to client (circle one) Mom StepMom

Name (last, first, middle)	Birth date Age	Social Security number
Street address (if different from above)	Cell phone	Business phone
City State Zip code	Employer	Occupation

Relationship to client (circle one) Dad StepDad

Name (last, first, middle)	Birth date Age	Social Security number
Street address (if different from above)	Cell phone	Business phone
City State Zip code	Employer	Occupation

Please list children here / If client is a minor list their siblings

Name	Birth date	Age	Living with you?	From a previous marriage? Place a check (√) if 'YES'

INSURANCE INFORMATION

Name of insurance provider	Patient's member or ID #	Copay amount $	Do you have EAP benefits? ☐ Yes ☐ No
Name of policy holder	Policy holder's Social Security #	Policy holder's DOB	Policy holder's employer