Client Information Sheet: Please fill out and sign

Personal Information

Name: ________________________________ Date of Birth: ___________Age: _____

Address: ____

City: ___________________State: _______ Zip: ___________

Home Ph: _______________ Work Ph: _______________ Cell ph: _______________

Email address: ____

Employer/School: ____________________Occupation/Studying: ________________

Relationship Status: ____

Children and Ages: ____

Referred by: ____

May I contact this person to thank them for the referral? Yes No

Primary Care Physician: ____

May I contact your PCP to let them know I am working with you? Yes No

Current medications and amounts: ____

____

Are you seeing any other health care professional such as a Naturopathic Physician, Acupuncturist or Massage Therapist? Please list: ______________________________

____

Briefly describe other ways you take care of your physical, mental and spiritual health.

____

____

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____

Are you or anyone else concerned about your current use of medication, alcohol or drugs? Yes No

Insurance Information
Your relationship to insured: Self Spouse Child Other

Insured's Name (if not Self) __________________________Date of Birth: ___________

Address: ____

City: ___________________State: ________Zip: __________

Home Phone: _______________________ Work Phone: ________________________

Employer/School: ____

Insurance Plan Name and phone #: ____

Insured's I.D. Number: ____________________ Group# ________________________

Authorization and Release
I authorize payment of medical or government benefits directly to Jeffrey Morrison, MA, LMHC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Client	Date
Print Name	Date of Birth (if under 13)