

Robert J. Smith, LCSW

Client Information Form

Today's date: _____

A. Identification (Couples & Families, please provide information on all names)

Name of Patient(s): _____
Last First M.I.

Date(s) of Birth _____ Social Security#(s) _____

Street Address _____ Apt.# _____

City, State, & Zip Code _____

Name of Patient(s): _____
Last First M.I.

Date(s) of Birth _____ Social Security#(s) _____

Street Address _____ Apt.# _____

City, State, & Zip Code _____

Calls and email will be discreet, but please indicate any restrictions: (E-mail may not be confidential)

Home Phone _____ Work Phone _____ Cell _____

Email Address _____

B. Emergency Contact: If an emergency should arise, and I need to contact someone close to you, whom should I call?

Name _____ Relationship _____

Address, City, & State _____

Home# _____ Work# _____ Cell _____

C. Referral: Who provided you with my name?

Name: _____ Phone: _____

Address: _____

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May I have your authorization to have communication with this person? Yes ___ No ___
How did this person explain how I may be of help to you?

D. Marital/Significant Other History:

Current Marital Status: Married Never Married Living Together Divorced Separated
 Remarried Committed Relationship Other: _____

Names and Ages of Parents _____

Names and Ages of Siblings _____

Names and Ages of Children _____

(*Please indicate if anyone is deceased or if there are any special issues)

E. Education and Training

F. Military Experience

G. Religious and Racial/Ethnic Background

Religious affiliation: Protestant Catholic Jewish Buddhist Hindu

Other (specify) _____

Formal Involvement: Active Some None

Which (if any) church, synagogue, temple, or meeting are you involved?

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How important are spiritual concerns in your life? _____

Ethnicity/National origin: _____ Race: _____

Or other way in which you identify yourself and consider important: _____

H. EmployerName _____
(Employers will not be contacted unless specifically requested)

Street Address _____

City, State, & Zip Code _____

Occupation _____

I. Primary Care Physician/Specialty Physician(s)

Name/Address/Phone _____

Name/Address/Phone _____

Please list any health/mental health problems, medications, allergies to medications, use of alcohol and illicit drugs:

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J. Financially Responsible Party If Different Than Above

Name _____ Address _____

City, State, & Zip Code _____

Home# _____ Cell# _____ Work# _____

Birthdate _____ Social Security# _____

Relationship to Client _____

Employer Name _____

Address, City, State, & Zip Code _____

Please Provide Copy of Insurance Card

Authorization# _____

I acknowledge receipt of the HIPAA Notice of Privacy Practices and Office Policies. I understand and agree to comply with these policies and practices.

X _____
Client Name Printed

X _____
Client Name Signature