Client Background Information Form

PATIENT INFORMATION

Name (last, first, middle)	Birth date Age	Today's date
Street Address	Social Security number	Gender ☐ Male ☐ Female

City State Zip code	Home phone	Work phone	Cell phone

Employer or school	Occupation or grade	Education (# of years)
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 address (for appt. reminders)	Referred by

Presenting problem

SPOUSE/ If the patient is a CHILD, then put the parents' information below

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

If your child is the patient please complete this section for your spouse/companion

Name (last, first, middle)	Birth date Age	Social Security number
Employer and profession	Home phone (or cell)	Business phone

CHILDREN OR SIBLINGS

Name	Birth date	Age	Living with you? Y or N	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