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# Client Information Form

This is a confidential record. Disclosure is expressly prohibited by law. Please provide the following information. Write in 'N/A' if it does not apply. Any information you provide will be treated as confidential. If you need more space for a response, please use the back side of the paper.

## A. General Information

Name:_____ Today's Date: _____/_____/_____
(First) (M.I) (Last)

Birth Date: _____/_____/_____ Age: _____ Gender: [ ] Male [ ] Female [ ] Transgender

Social Security #: _____

Local Address: _____
(Number and Street)

_____
(City) (State) (Zip)

Home Phone:_____ Cell Phone: _____

May I leave a message? Home: [ ] Yes [ ] No Cell: [ ] Yes [ ] No Text Cell: [ ] Yes [ ] No

Email: _____ May I email you? [ ] Yes [ ] No

Emergency contact:_____ Relationship:_____

Cell #:_____ Work #_____ Home #_____

**Primary Concerns:**

What brings you to my office today?

What are effective coping strategies you have learned?

What are your hopes or goals for treatment?

What do you consider to be your strengths or things you like about yourself?