Client Information Form (Adult)

Intake Date:_____ **Clinician:**_____

Patient's Name: _____ **Social Security #**_____
First Middle Last

Address:_____
Street City State Zip

Birth Date:_____ **Age:**_____ **Sex:**_____ **Martial Status:**_____

Home Phone:_____ **Work Phone:**_____

Employer Name:_____

Address:_____
Street City State Zip

Spouse's Name:_____
First Middle Last

Address:_____
Street City State Zip

Home Phone:_____ **Work Phone:**_____

Employer Name:_____

Address:_____
Street City State Zip

Other Family Members Living at Home (Children, Step-Children, other Relatives):

Name:	Date of Birth	Age	Relationship to Patient
1.			
2.			
3.			
4.			
5.			

Person Responsible for Payment of Bill:_____
First Middle Last

Address:_____
Street City State Zip

Telephone_____ **Driver's License #**_____ **S.S**