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NEW CLIENT INFORMATION

DATE :_____________________________

CLIENT NAME:____ BIRTH DATE : ______________________

ADDRESS:____

____

PHONE
H) ____________________________ W) ________________________ C)________________________

OCCUPATION OR NAME OF SCHOOL ____

PREVIOUS PSYCHOTHERAPY OR HOSPITALIZATION? ( ) YES ( ) NO
IF SO, WHERE? WHEN? ____

CURRENT MEDICATION OR DRUGS, INCLUDE NAME, FREQUENCY, USE AND DOSAGE

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Name of Family Members Occupation	Education	Birth Date	Relationship

____

CURRENT HEALTH PROBLEMS; ILLNESSES, DISABILITIES AND TREATMENTS. INCLUDED NAME OF PHYSICIANS
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____

WHO REFERRED YOU? ____ MAY WE CONTACT THIS PERSON? ________

CLIENT OR GURADIAN'S SIGNATURE ____

____

OTHERS IN HOME ____________________________________ RELATIONSHIP ____

____ RELATIONSHIP ____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY: ____

PHONE : H) ____ W) ____