Deborah Sloss, LCSW

Client Information Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Date:_____ Birth Date:_____

Client's Name:_____Age:_____

Address:_____

_____

Insurance Info_____

Home phone: _____ Cell phone:_____

E-Mail_____

Parent/Guardian Name:(if client is a minor)_____
Relationship:_____ _____

Address:(if different than above) _____

Email:_____ _____

Home phone:_____ Cell phone:_____
Ok to leave a message? Yes__ No__
Emergency Contact Name and Phone:_____
Relationship:_____

Physician: _____Physician's phone:_____

Current medical problems:_____

Prescription medications and dosages:

_____

Ds cif 1/16

Party Responsible for payment:_____

How were you referred to my practice?_____

Current concerns:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

(please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing, including issues with sleeping or eating

_____

_____ _____

2. Are you currently experiencing sadness, grief or depression? _____

If yes, for approximately how long? _____

3. Are you currently experiencing anxiety, panic attacks or have any phobias?_____

If yes, when did you begin experiencing this? _____

4. What significant life changes or stressful events have you experienced recently?

_____ _____

5. What would you like to accomplish out of your time in therapy?

_____