

CLIENT INFORMATION FORM

Date: _____

Name: _____

Address: _____

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

Cell: _____ **E-mail:** _____

Date of birth: _____

Please place initials next to the phone numbers I can use to contact you or leave messages at.

Name of person who referred you: _____

Responsible party if other than client: _____

Address: _____

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

Cell: _____ **E-mail:** _____

Relationship to client: _____

Guardian **GAL** **Power of Attorney**

Emergency contact if different from above: _____

Address: _____

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

Cell: _____ **E-mail:** _____

Relationship to client: _____

Physician: _____ **Phone:** _____

Other specialists and phone numbers: _____

Medical diagnoses: _____

Mental Health History (include previous psychotherapy, psychotropic medication history and diagnoses):

Current Medications: _____

Non prescription medications: _____

Caffeine per day: ____ **Cigarettes per day:** ____ **Alcohol per day:** ____

Allergies: _____

Education: _____

Occupation: _____

Currently employed? _____ **If not, date last worked:** _____

Do you have health insurance that covers mental health services? (If yes, please check with your insurance company regarding reimbursement for my services).

Do you have Medicare Part B? (If yes, please note that I have elected to opt out of Medicare and therefore my services are not reimbursable by Medicare).

Please describe presenting concerns you would like help with :

Other comments? _____

Please fax to: Henriette Kellum LCSW, Fax# 703 439-2502 or bring to the office at your first appointment.

Please do not e-mail confidential client information.