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Client Information

Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. For couples and family therapy, each person should complete a set of all four pages. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with Dr. Davidson. All information is **CONFIDENTIAL**.

Your Name (First, Middle Initial, Last)

Address _____

City/State/Zip _____

Phone #s: Home _____

Work _____ Cell: _____

Email : _____ Ok to Email Statements/Invoices? _____

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No ___ Yes ___ (If Yes, please be specific) _____

Age _____ Birth Date _____ Social Security # _____

Occupation _____

Employer _____

Single ___ Married ___ (# years _____) Partnered ___ (# years _____) Separated ___ Divorced ___

Widowed ___ Other ___ (specify) _____

Names and ages of children _____

Spouse's/Partner's Name _____

Age _____

Spouse's/Partner's Occupation _____

Significant medical problems you have or had _____

Current Physician: _____ Phone # _____

Current medications you are taking _____

If you have had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

If you are currently working with any mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

Primary Insurance Information
Insurance Company and Type (HMO, PPO, etc.) _____

Member ID # _____

Group/Plan# _____

Insurance Phone # (for benefit or claims information from your card)

Claims address (from your card)

Are you the policy holder? Yes ___ No ___ If no, complete the following about the policy holder:

Policy holder's name _____

Address & Phone # (only if different than yours)

Birth Date _____ Social Security # _____

Employer _____

Your relationship to policy holder _____

PLEASE PROVIDE YOUR INSURANCE CARD TO BE COPIED

