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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. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with your clinician. All information is CONFIDENTIAL.

Your Name (First, Middle Initial, Last) _____

Preferred Pronouns: _____

Address _____

City/ Region/ Post Code _____

Phone #s: Home _____

Work _____ Cell: _____ Ok to text? _____

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 _____ NHI#: _____

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/GP Group: _____ 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:

SIGNATURE

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information my clinician as soon as possible.

Client Signature

Date

I give my permission for Dr. Davidson to speak and consult with my physician/GP listed on the previous page and any other treating medical professionals listed below in order to coordinate my care and provide me the highest standard of care.

Client Signature

Date