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CLIENT INFORMATION FORM

Date _____

Client Name _____

Date of Birth _____ Age _____ Gender _____

Address _____

City/State/Zip _____

Phone (Cell) _____ (Home/Work) _____

Email _____

Place of Employment/Occupation OR School/Grade _____

Responsible Party's Name/Address (*if different from above*) _____

_____

Primary Insurance Co. _____

Policy ID # _____ Group # _____

Insurance Co's Behavioral Health Phone # _____

Policy Holder's Name (*if different from above*) _____

Address _____

Date of Birth _____ Phone # _____

Emergency Contact _____

Relationship _____ Phone # _____

Emergency Contact _____

Relationship _____ Phone # _____

Who referred you _____

Primary Care Physician _____

Previous/Current Therapist _____

Previous/Current Psychiatrist _____

Current Medications/Treated Condition _____

_____

Current Medical Issues _____

Please describe your primary reasons for seeking EMDR therapy _____

_____

Please indicate if you are experiencing any of the following type of symptoms or problem areas:

Anxiety ____ Depression____ Mood Swings ____ Sleep ____ Relationship _____

Substance Abuse ____ Behavioral ____ Eating ____ Work/School _____

Memory/Concentration _____ Flashbacks/Nightmares ____ Avoidance ____

Current Marital/Partner status _____ Name of significant other _____

Names of Children _____

If Child is the Client:

Names of Biological Parents _____

Names of Step-Parents _____

Names of Siblings _____

Persons currently living with you:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____