Dr. Judy Chamberlin LCSW, PsyD

Individual, couples and family counseling
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CLIENT INFORMATION FORM

Client Name: ____ Date of Birth: _______________

Address: _____________________________ City_______________ State: ______ Zip: _______

Home Number: __________________________ Mobile Number: __________________________

Work Number: __________________________ Email: ________________________________

Emergency Contact ________________________________ Phone number__________________

Ethnicity (optional): ______________________ Religion (optional) __________________________

Education: ____________________________ Occupation: ______________________________

Relationship status (circle one) Married Life-Partner Engaged Single Separated Divorced Widow

Spouse/Partner Name: _____________________________ Age: ______ Years Together________

Others living in your home:

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship __________

Previous Therapist: ______________________________ _ How long: From_______ to__________

Previous Therapist: ______________________________ _ How long: From_______ to__________

Current Psychiatric Medication: ______________________ Prescribing Doctor _________________

Current Health Problems: ____

Who May I thank for referring you to this office:

_______________________________ _______________________________ __________

Name Address Phone

Other Referral Source: