Asbury Park Psychotherapy Associates

Client Information

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date_____ Client's Social Security #_____

Name_____

Address_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____Cell_____

Birthdate___/____/____ Age____Gender __F __M e-mail_____

Name of Spouse/Guardian_____Phone_____

Person Responsible for Payment_____Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____Relationship_____

Phone_____Work_____Cell_____

Address_____City_____State_____Zip_____

Name (2) _____Relationship_____

Phone_____Work_____Cell_____

Address_____City_____State_____Zip_____

Physician_____ Phone_____

Address_____ City_____State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

Current Medications_____

Allergies_____

Referral Source

Whom may we thank for referring you?_____

Address_____ City_____ State_____ Zip_____

Phone_____ Relationship to referral source_____

If you were not referred by someone, how did you find out about us?_____

What is the nature of your problem?_____

What kinds of symptoms are you having? Be specific._____

How long have you had these symptoms or this problem?

Have you ever had counseling before? If so, when? Where?

Do you use alcohol? How much do you drink in a day or week?

Do you use drugs? Which ones? How much? How often?

Do you think you have a drug or alcohol problem?

Anything else you would like to share (continue on reverse side if necessary)

What are your goals for therapy?