CLIENT FACT SHEET

Please print

Name: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____

Address (include zip code): _____

Email Address: _____

Date of Birth_____ Social Security # _____

Insurance Name: _____ Subscriber #:_____ Group #_____

Name of person who holds the insurance policy and their date of birth, work place, work address, and work phone. _____

Relationship Status (circle one) married single divorced widowed partnered:

Partner's Name (optional) _____

Emergency Contact Person: _____ _____ _____

Name Relationship Phone Number

Employment Information:

_____ _____ _____

Employer Name Employer Address Employer Phone Number

Please describe yourself in terms of:

Age: _____ Gender: _____ Education: _____

Race: _____ Ethnicity: _____

Occupation: _____

Physical limitations: _____

Sexual orientation: _____

Religious/Spiritual practice: _____

Other: _____

In general, describe the interest that brought you to seek these services:

_____

_____

Please provide the names and telephone numbers of medical professionals that you are seeing now or have consulted in the past 12 months:

_____

_____

When was your most recent physical examination? _____

Please list any prescription medications (and dosage) you are currently taking or have taken in the past 12 months: _____

_____

Please list any known allergies: _____

Please list any self-help or facilitated groups that you currently take part in or have participated in during the past 12 months: _____

To the best of my knowledge, the above information is complete and I consent to therapy services with Dr. Mary Ann Hartnett. Release of any information to any service provider will be made only with a specific written release, signed by me. A copy of the **Cancellation Policy** was provided to me; I have read it and I understand and accept all provisions of service set forth in them.

_____
Print Name

_____ _____
Signature date

This data is confidential and I will keep it secure. Mary Ann Hartnett, PhD. LCSW