Clinical Service Client Face Sheet – All Ages

Personal Information:

Name				Date	
Address:			*Email Address:*	Phone #	
				Alternate #	
Date of Birth	Age	Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other		Race/Ethnicity	Place of Birth

Children:

Parent #1 Name:	Phone #:	Email:
Parent #2 Name:	Phone #:	Email:
Emergency Contact Name, Relationship, & Phone #:		

Reason For Referral – Current Symptoms:

Previous Mental Health Treatment, Diagnosis, Therapists, & Dates of Service:
Psychiatric Medications *(past & current)*:
Psychiatrist Name & Phone #:

Medical Diagnosis:
History of Hospitalizations & Surgeries:
Medications *(past & current):*
Primary Care Physician Name & Phone #

Form Completed by:

Rev 10/22