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Client Information Sheet

Client Name_____ DOB_____S.S. #_____
Age_____ Gender_____ Marital Status_____ Ethnicity _____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Can we leave a message? __ Yes __ No
Email Address _____Preferred contact method: Phone __ Email __

Employer_____ Job Title _____
Address_____ Phone _____

Students: Grade/Level _____ School_____
Address_____Phone_____

Primary Physician_____ Date of last visit_____ ☐No Primary Physician
Address_____Phone_____

Psychiatric Prescriber _____ Date of last visit_____ ☐ No Psychiatric Prescriber
Address _____ Phone_____

Emergency Contact_____ Relationship_____
Address_____Phone_____

Who referred you to this office? _____
Address_____Phone_____

Reasons for referral?

_____

_____

_____

Client or authorized person's signature: I authorize Dr. Kim to make contact with the referral source, my physician and my prescriber, for purposes of treatment planning and coordination of care.

_____ _____
Signature Date

_____
Printed Name