CLIENT INFORMATION & HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential and will be used for the purpose of the evaluation.

Today's Date_____

PERSONAL HISTORY

Client Name _____

Date of Birth_____ Age ___ Marital Status_____ Children_____

Home Address_____

City_____ State___ Zip Code _____Email:_____

Home Phone (_____) Work Phone (_____) Cell Phone (_____)

Driver's License:__ _____ Social Security: _____

Education:_____ Occupation:_____

Employment Status_____ Are you on Disability_____

Employer _____Years at Job_____

Emergency Contact Name and Phone:

How were you referred to Dr. Khoie?

MEDICAL & PSYCHYIATRIC HISTORY

Do you have a medical or psychological diagnoses?

What are your current medications?

Are you currently under the care of a physician or a psychiatrist?
If yes, please indicate the name(s) of your provider(s) and the reason(s) you receive care?

I acknowledge that the information I have provided is true and I am responsible for the unpaid fees associated with the services provided to me by Dr. Khoie.

_____ _____

Signature Date