Resilience & Transformation
PSYCHOTHERAPY CENTER

Confidential Client Information

Client's Name _____-- Today's Date: _____

Address _____ Date of Birth _____

_____

_____

Home Phone _____ Work Phone: _____

Cell Phone _____

Email _____

May we call you at home? ❒ Yes ❒ No Okay to leave a message at home? ❒ Yes ❒ No
May we call your cell? ❒ Yes ❒ No Okay to leave a message on cell? ❒ Yes ❒ No
May we text your cell? ❒ Yes ❒ No May we email you? ❒ Yes ❒ No

Person to notify in the event of an emergency _____
Emergency Contact's phone number _____ Relationship: _____

List family members and others in your home:

Name	Age	Relationship	Occupation

Medications and Supplements Taken

Medication	Dosage	Prescribing Physician

Current Treatment Providers

	Name	Phone	Last Seen
Physician			
Psychiatrist			
Other			