BELL CENTER FOR ANXIETY AND DEPRESSION

Client Information Form

Date: ___________________

Client Name: ____

Address: ____

____

		Call?	Msgs?			Newsletter?
Home Phone:	______________	☐	☐	E-Mail:	______________	☐
Work Phone:	______________	☐	☐	Date Of Birth:	______________	
Cell Phone:	______________	☐	☐	Age:	______________	
Gender:	______________			Preferred Pronouns:	______________	

Referred By: ____

Medication(s): ____

Physician(s): ____

☐ Check if the client is the financially responsible party.

Additional Information for Spouse and Parents/Guardians

Name:	______________	Name:	______________
Relationship:	______________	Relationship:	______________
Address:	______________	Address:	______________
	______________		______________
E-Mail:	______________	E-Mail:	______________
Home Phone:	______________	Home Phone:	______________
Work Phone:	______________	Work Phone:	______________
Cell Phone:	______________	Cell Phone:	______________

☐ Check if this individual is the financially responsible party.

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Emergency Contact Information

Name: ____

Address: ____

Phone: ______________ Relation: ______________

________________________ ________________________

Signature* Date

________________________ ________________________

Print Client's Name Relationship to Client

*If parents are ***separated*** or ***divorced*** and have ***joint custody*** of the client, then both parents' signatures are *required.* Only one parent's signature is required if parents are married to each other.

________________________ ________________________

Additional Parent Signature Date

________________________ ________________________

Print Name Relationship to Client

Revised: 9/28/21