Sarah E. Burgamy, Psy.D.
490 South Logan Street
Denver, CO 80209

CLIENT INFORMATION FORM

Date: ____________________

Client Name: ______________________________ Date of Birth: _________________

Address: ____________________ City _________________ State ______ Zip _________

Social Security #: ___________________________

Home Phone: ______________________ Work Phone: _____________________

Cell Phone: ________________________

Emergency Contact Name: ________________________ Relationship to Client:__________________

Phone Number: ________________________________

Who referred you?: ______________________

Please briefly describe what brings you in today?:

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Previous Counseling and/or Psychiatric Treatment:
(Please include name of provider, length and focus of treatment)

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Medications (Please include dosages if known):

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FOR CLIENTS 18 AND YOUNGER:

Legal Guardian Name: ________________________________

Address: _____________________ City _________________ State _____ Zip ________

Social Security #:_____________________________

School: ____________________________________ Grade: ____________

Emergency Contact Name: ___________________________ Relationship to Client:______________

Phone Number: ____________________________________

Medications (Please include dosages if known):

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AS YOU KNOW, **PhoenixRISE and SARAH E. BURGAMY, PSY.D.** CONDUCT A PRIVATE PAY PRACTICE AND DO NOT DIRECTLY BILL INSURANCE COMPANIES. PLEASE INDICATE IF YOU PLAN ON SUBMITTING BILLING STATEMENTS TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT: Yes: __________ No: ___________