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: ________________________ Email:_______________________________________

Emergency Contact Name: ________________________ Relationship to Client:__________________

Phone Number: _________________________________

Who referred you?: ______________________

Please briefly describe what brings you in today?:

____

____

____

____

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

____

____

____

Medications (Please include dosages if known):

____

____

____

[Continued on next page]

FOR CLIENTS 18 AND YOUNGER:

Legal Guardian Name: ________________________________

Address: ______________________ City __________________ State ______ Zip _________

Social Security #:______________________________

School: ______________________________________ Grade: _____________

Emergency Contact Name: ____________________________ Relationship to Client:_______________

Phone Number: _____________________________________

AS YOU KNOW, **PhoenixRISE** CONDUCTS A PRIVATE PAY PRACTICE AND DOES NOT DIRECTLY BILL INSURANCE COMPANIES. PLEASE INDICATE IF YOU PLAN ON SUBMITTING BILLING STATEMENTS TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT:

Yes: ___________ No: ____________