8771 Wolff Ct., Suite 210
Westminster, CO 80031
Telephone: (303) 257-7623
Fax: (303) 427-2378

19 Old Town Square, Suite 238
Fort Collins, CO 80524
(970) 324-6928

Client Information Form

Name:________________________________ Today's date:____________
Address:__________________________ City _____ State___ Zip_______
Telephone Numbers H:___________________ W:_____________________
Cell:__________________ Date of birth:___________
Marital Status (Please circle one): single, married, separated, divorced, widowed

Employer:_______________________ Occupation:___________________
Employer's Address:____

Name of spouse:__________________ Occupation:___________________
Spouse's employer:________________ Spouse's work phone:___________
Spouse's cell phone:_______________ Spouse's date of birth:___________
(needed only if spouse will be in therapy)

Family members: Name / Age / Relation / Live with you?
____
____
____
____
____

Referred by:_______________________ Physician:____________________

Previous psychotherapy? Yes/No If Yes, therapist's
name:_______________
State in your own words the nature of your chief complaint:_____________
____
____
____