The Glenbrook Therapy Center

Client Information Form

Name: _____ Date: ___/___/___

Address: _____ Home Phone: (_____) _____

_____ Mobile: (_____) _____

E-mail: _____ SSN (optional): _____

Date of Birth: ___/___/___ Marital Status: _____

Names of Members of Immediate Household:	Age	Gender	Relationship
_____	_____	❑ F ❑ M	_____
_____	_____	❑ F ❑ M	_____
_____	_____	❑ F ❑ M	_____
_____	_____	❑ F ❑ M	_____

Client: ❑ Employed Full Time ❑ Employed Part Time ❑ Full-Time Student ❑ Part-Time Student

Employer/School: _____ Job Title: _____

How long there? _____

Address: _____ Work Phone: _____ Ext.: _____

_____

Spouse: ❑ Employed Full Time ❑ Employed Part Time ❑ Full-Time Student ❑ Part-Time Student

Employer/School: _____ Job Title: _____

How long there? _____

Where did you hear about us? / Who referred you to us? _____

If by internet search, which search engine and search terms (if you recall): _____

Reason for this call: _____

_____

_____

How long has this been a problem? _____

_____

Previous therapy: _____

_____

Relevant medical condition(s)/treatment(s): _____

_____

Questions/Concerns/Expectations: _____

_____