CLIENT INFORMATION

Please fill in all applicable fields:

Client Name_____ Date_____

Mailing Address _____

City _____ State _____ Zip Code_____

Home Phone_____ Business Phone _____

Mobile Phone _____ Email _____

How would you prefer Dr. Vlietstra to contact you?

□ Home Phone □ Business Phone □ Mobile Phone □ Email □ Other_____

What is your marital status?

□ Single □ Married □ Divorced □ Separated □ Widowed

Date of Marriage/Divorce _____

How were you referred to Dr. Vlietstra? □ Client □ Doctor □ EAP □ Website □ Other___

How would you describe the problem which brings you here?_____

_____

Client & Family Members	Age	Birthdate	School/Occupation	Phone#
_____ Client name	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you been seen by a psychologist or counselor before?
If so, by whom?_____ When?_____

Medical History: Physician or health care practitioner (within the last two years)

_____

Method of Payment: □ **Self-pay and/or Copay_____** □ **Insurance** _____
Patient Soc. Sec. No.: _____-____-_____ Authorization No. _____

Who is responsible for the bill *(only if information is different from above)*?

Name_____ Occupation_____
Address_____ Employer_____
City/Zip_____ Phone #_____