Integrative Psychological Services
Sarah Turner, Ph.D.
Clinical Psychologist, PSY17347

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CLIENT INFORMATION FORM

Last Name (Client/Minor)_____________________________ First _______________________ MI. ______ Age_____

DOB _______/_______/_______ Social Security # ________ - ______ - ________

Address _______________________________________ City ______________________ State ___ Zip________

Phone# (_____)__________________________ Work Phone# (_____)_____________________________________

Employer _______________________________ Occupation ____

Emergency Contact____ Phone #(_____)_________________________

Parents' Names/Addresses (If client is a minor):

Mother: ___________________________________ DOB: ___/___/___ Social Security # ______-____-________

Father: ___________________________________ DOB: ___/___/___ Social Security # ______-____-________

Address (If different than above)____ City ____________________

State _______ Zip ________ Phone# (_____)__________________Email address__________________________

School Attending (Minor) ____

Family members living in the home (Name, DOB, Relationship):

____

____

____

CLIENT HISTORY

Have you (Minor) had previous therapy? Yes No

If Yes, What was the reason for therapy?

____

Name of Therapist: ____

Diagnosis(?):____ Date Given:_______________

Are you/or (Minor) currently taking any medications? Yes No
If Yes, what medication(s) and what mg(s)____

____

(OVER)

Additional Information (If Needed)

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Authorize to Release Information

I hereby give Dr. Sarah Turner authorization to release/receive information from my insurance carrier and her billing agent. Information will be limited to the facts relevant to reimbursement and billing inquiries only. I also give Dr. Sarah Turner permission to fax data to my insurance carrier and her billing agent.

Signature: ____ Date: ___________________________________

Relationship to client (If client is a Minor): _____________________________