Client Information Form

Salt City Psychology, LLC
77 South 700 East Suite 220
Salt Lake City, UT 84102
801-758-7370

Client/Patient Information:

Client/Patient Name: _____ Date of Birth: _____

Address: _____
City: _____ State: _____ Zip Code: _____

Home Phone: _____
Mobile Phone: _____
Work Phone: _____

Email Address: _____

Employer/School: _____
Employer/School Address: _____
City: _____ State: _____ Zip Code: _____

Previous Counseling and/or Psychiatric Treatment:

Name of Provider: _____
Length of Treatment: _____
Medications (please include dosages if known):
_____
_____

Emergency Contact Information:

Name: _____ Relationship to Client: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Home Phone: _____
Mobile Phone: _____
Work Phone: _____

Who Were You Referred By?

Name: _____

May I contact this person to thank them? Yes: _____ No: _____

Responsible Party:

If you are the parent or legal guardian of a client/patient who is under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section of this form.

Name of Parent or Legal Guardian: _____ Date of Birth: _____
Social Security Number: _____

Address: _____
City: _____ State: _____ Zip Code: _____

Home Phone: _____
Mobile Phone: _____
Work Phone: _____

Email Address: _____

Employer: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

I certify the information provided above is accurate to the best of my knowledge. I also authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

_____

Signature of Client or Legal Guardian **Date**