Salt Lake Marital and Family Therapy Clinic
1399 South 700 East, Suite 11
Salt Lake City, Utah 84105

FOR OFFICE USE ONLY
THERAPIST:
INTAKE DATE:
DIAGNOSIS:
COMMENTS:

CLIENT INFORMATION FORM

Client Information

Full Name _____ Social Security Number _____
Birth Date _____ Age _____ Sex: M F Marital Status: Single Married Divorced Separated Other_____
Address_____ City_____ State _____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Occupation _____ Employer_____

Insurance Information

Name of Insurance Company_____ Name of Policy Holder_____ Birth Date:_____
Address of Insurance Company _____ Phone _____
Social Security Number/Policy Number_____ Employer _____
Do you have Secondary Insurance? Please list here_____

Referral Source

How were you referred to us? _____

Presenting Problem

Reason for seeking therapy?_____

Therapy History

Have you ever received therapy before? ____Individual _____Couples Was it helpful?_____
Are you currently seeing a psychiatrist? _____ Name_____
Address _____ Phone Number _____
Are you currently taking any psychotropic medication? Please list _____

Emergency Contact

Name _____ Relationship to Client _____
Home Phone _____ Work Phone _____Cell Phone _____

Contact Information

By initialing, I agree that the Salt Lake Marital and Family Therapy Clinic may contact me at and leave messages for me at the following phone numbers and/or email addresses:

Client #1 (Initial here) _____ (List numbers/email addresses here)_____

Client #2 (Initial here) _____ (List numbers/email addresses here)_____