Holly Lien, MA, LMFT LICENSE # MFC 35076 1736 Picasso Ave., Suite A, Davis, CA 95618
Holly@HollyLien.com (530) 220-3433 Specializing in Individual & Family Therapy, Adolescents, & Adoption

Client Information Form

Name:____ **Gender:**_______________

Address:________________________________ **City:**____________ **State:**_____ **Zip:** _______

Phone (home)**:**____________________ (cell)**:**____________________ Check if okay to receive texts: ☐

Email: ____________________________ **Age:**_______ **Date of Birth:**____________________

Occupation: ____

If client is over the age of 14, best phone or email to contact them on appt. day: _______________

Relationship Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Partnered / Domestic Partnership**

Any Religious affiliation: ____________________ **Referred by:**_________________________

With whom do you live? (names/ages): ____

Name of person(s) financially responsible:________________________**Date of Birth:**_________

Address:_______________________________ **City:**____________ **State:**_____ **Zip:**_______

Reason for seeking services: ____

____

Emergency contact (name, relationship, & phone)**:** ______________________________________

- Medical History -

Current Primary Care Physician (name & phone)**:** _____________________________________

Date of last physical exam: _________________ **with whom:**___________________________

Significant medical history (surgeries, accidents, illnesses, etc.)**:** __________________________

____

Past or Current History and/or treatment of:

☐ **Asthma**	☐ **Chronic Pain**	☐ **Thyroid Problems**	☐ **Depression**
☐ **Seizures**	☐ **Chronic Fatigue**	☐ **Hypertension**	☐ **Panic Attacks**
☐ **Diabetes**	☐ **Eating Disorder**	☐ **Anxiety**	☐ **Suicidal Thoughts**
☐ **Migraines**	☐ **Cardiac Problems**	☐ **Other** _______________	

(Over – Please continue filling out page 2 of this form)

Current medications (name, dosage, & date started)**:** ______________________________

____

Prescribing doctor (name & phone number)**:** ______________________________

Past psychiatric medications (include names, dosages, & response)**:** ______________________________

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Chemical use history:

Alcohol: ______________________________

Street drugs: ______________________________

- - - - - - - - - - - - - - - - - Mental Health History - - - - - - - - - - - - - - - - -

Previous mental health services ☐ **Yes** ☐ **No** **Provider & Dates:** ______________________________

____

Outcome of previous mental health services: ______________________________

Previous psychiatric hospitalizations: ☐ **yes** ☐ **no** (if yes, please list dates and hospital)**:**

____

Previous Suicide Attempts: ☐ **yes** ☐ **no** (if yes, please list dates)**:** ______________________________

Please briefly explain any legal or criminal history: ______________________________

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- - - - - - - - - - - - - - - - - Insurance Information - - - - - - - - - - - - - - - - -

(Note: **Please don't leave any section blank.**)

Check here if you are NOT **billing your insurance, and are instead paying privately**: ☐

Name of insured's employer: ______________________________

Name of your insurance company:______________________________ **Phone:**____________________

Primary insured's name:______________________________ **Date of birth:**____________________

Primary insured's ID#:______________________________ **Group#:**____________________

Insured's address:______________________________ **City:**__________________ **State:** _____ **Zip:**__________

Copay amount: _______________

Your relationship to the insured (check one)**:** ☐ **self** ☐ **spouse** ☐ **child** ☐ **other:** __________________

I hereby authorize the release of any medical or other information necessary to process medical insurance or EAP claims related to treatment. I authorize direct payment to Holly Lien, LMFT for insurance reimbursement of covered services.

Date:_____________________ **Signature:**______________________________