CLIENT INFORMATION FORM

Today's Date:		Client Name:	
Date of Birth:		Preferred Pronouns:	
Guardian Name (if client is a minor):			
Client Address:	Street		Apt #
	City, State, Zip Code		
Client/Guardian Phone Numbers:	Cell	Home	
	Work	Can I leave a message? ☐ Yes ☐ No	
Client Email Address:		Guardian email address	
Emergency Contact (Name & Relation):		Phone	

Please list all members of your household, *including yourself*:

Name	Relationship	Age/DOB	School/Grade/Occupation

Insurance & Medication

Do you have medical insurance?	☐ Yes ☐ No
Who is your insurance carrier?	
Do you have Badgercare (non-HMO)?	☐ Yes ☐ No
If yes, what is your Forward Health ID #?	
Do you currently take medication? Please list names and dosage.	
Psychiatrist's Name & Contact Information:	

What concerns cause you to seek out therapy at this time?

What would you like to see happen as a result of coming here?

What have you tried on your own to change this issue(s)?

Have you ever had therapy before? If so, what worked during the time you were with them?

Who referred you to Rainbow Marifrog, LLC?