

**WENDI L. DUMBROFF, MA, LPC, LLC
2 GREEN VILLAGE ROAD, SUITE 202
MADISON, NJ 07940**

CLIENT INFORMATION

Name

Address

Zip _____

Phones: Cell: _____ May messages be
left? _____

Home: _____ May messages be
left? _____

Work: _____ May messages be
left? _____

Age _____ Date of Birth _____ Gender (male/female)

Marital Status _____

Employer

School and Grade

Social Security Number

Vehicle: (make, model, color)

License Plate Number:

Immediate Family Members:

Name	DOB	Relationship
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact Information:

1. Name: _____ Relationship: _____

Address:

Zip _____

Cell: _____ Home: _____ Work: _____

2. Name: _____ Relationship: _____

Address:

Zip _____

Cell: _____ Home: _____ Work:

If you are currently in therapy with another individual, or if you have been in therapy in the past, please provide the name(s) and contact information for any previous or current therapists.

NOTE: NO CONTACT WILL BE MADE WITHOUT YOUR WRITTEN CONSENT TO DO SO

Are you currently under the care of a psychiatrist, or have you been in the past? Please provide their contact information.

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Name:

Address:

Phone:

Have you ever:

- Been hospitalized for psychiatric treatment?
- Had intensive out-patient (IOP) treatment?
- Been in partial care hospitalization treatment?
- Been in any type of residential treatment?

Please provide dates and details of any of these treatments below (Use back of sheet if necessary):

Are you currently taking any prescription or over-the-counter medications or supplements, or, have you taken any medications in the past, which you no longer take?

Medication and Dosage For What Condition? When did you start/stop taking?

Who is your primary care physician?

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CONSENT TO DO SO**

Name:

Address:

Phone:

Date of last physical:

Are there any guns or other weapons in the home?

Please share any medical or mental health concerns, or any other concerns you may have:

Client's Signature _____ Date

Signature of Responsible Party _____ Date

All Information Will Be Kept Confidential As Permitted By Law