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? _____

E-mail address: _____ May I E-mail you? _____

Age _____ Date of Birth _____ Gender (male, female, trans m/f, fluid) _____

Marital Status _____

Employer _____

School and Grade _____

Social Security Number _____

Vehicle: (make, model, color) _____

License Plate Number: _____

Immediate Family Members:

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

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

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?
NOTE: NO CONTACT WILL BE MADE WITHOUT YOUR WRITTEN 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