SALLY CROCKER, LCSW
CLIENT INFORMATION

All information shared on this form and through discussion is confidential. Please refer to Sally's privacy policies for how your information will be safeguarded and what legal exceptions allow release of your information.

NAME_____

ADDRESS_____ HM PH_____

CITY_____ ZIP_____ WK PH_____

DATE OF BIRTH _____ CELL PH_____

EMAIL_____

LAST SCHOOL GRADE OR DEGREE COMPLETED_____

OCCUPATION_____ EMPLOYER_____

MARITAL STATUS (please circle) SINGLE COHABITING MARRIED

REMARRIED DIVORCED WIDOWED

PLEASE LIST ANY HEALTH PROBLEMS_____

_____

ANY CURRENT MEDICATIONS_____

BY WHOM WERE YOU REFERRED_____

If you need to miss a scheduled appointment, you will need to cancel at least 24 hours in advance. If an emergency prevents your coming, please let me know as soon as possible.

If you are planning to file an insurance claim to request reimbursement for my fee, I want you to understand that assessment and/or treatment information may be required in order for the claim to be paid. Please feel free to ask me any questions about this that you may have. By signing below, you authorize the release of such information necessary to have claims processed and acknowledge your acceptance of my cancellation policy.

Signature:_____ Date:_____