From the Office of
Judith Schulman-Miller LCSW
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Client Information Form

Client Name_____ _____ Date of Visit_____
Address_____
City_____ State_____ Zip_____

Home Telephone_____ Permission to call?_____ Leave Message?_____
Work Telephone_____ _Permission to call?_____ Leave Message?_____
Cell Telephone _____ __Permission to call?__ Text?__ Leave Message?_____
Email Address_____
Date of Birth_____ Marital Status____ Referred by_____
Insurance #_____Name of Insured_____ Date of Birth_____
Employed by _____ Position_____
Name of Partner_____
Employed by_____ _____ ___ Position_____
Name and Ages of Children and others in your household
_____
_____
Primary Care Physician_____ Telephone_____
Emergency Contact _____ Telephone_____

Current Medications_____
_____
_____

Previous Counseling History: (therapist, dates, problem, outcome)
_____
_____

What concerns bring you here today?
_____
_____
_____
What would you like to happen as a result of coming here?
_____
_____
_____